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ABSTRACT

This document is comprised of the six 2000 issues of a bimonthly newsletter providing information on young children's health and safety for California's child care professionals. Regular features include a column on infant/toddler concerns, a question-answer column regarding medical and health issues, a nutrition column, and resources for child care providers. Periodically featured is information on behavioral, diversity, and school-age care issues. The feature articles for each issue are as follows: (1) "Changes Made to 15-Hour Health and Safety Training Requirements" (Jan-Feb); (2) "Child Care Health Consultation: The View from the Health Department" Mar-Apr); (3) "What Is a 'Medical Home?'" (May-Jun); (4) "The Right Call for Poison Help" (Jul-Aug); (5) "Let's Talk about Prescriptions" (Sep-Oct); and (6) "Twenty Percent of SIDS Deaths Occur in Child Care" (Nov-Dec). (KB)

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Child Care Health Connections, 2000.

A Health and Safety Newsletter for California Child Care Professionals.

Volume 13, Numbers 1-6.

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A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

January-February 2000 Volume 13, No. 1

Changes made to 15-hour Health and Safety Training requirements

There are still a lot of questions about how 1998 legislation (SB 1524) will impact child care providers needing to take the First Aid, CPR and Preventive Health Practices training. As we interpret the proposed Emergency Medical Services Authority (EMSA) regulations, it appears that providers should be aware of and consider the following points:

- When registering for a class, ask the instructor if he or she is part of an "Approved Training Program" and if the course completion cards or certificates will have an "EMSA Course Completion Sticker." These were required as of September 1999; however, community college courses are exempt from this requirement.
- When registering for a First Aid class, ask the instructor if the course will include training in the "use of inhaled medications and nebulizers for children with lung diseases such as asthma." This is a new requirement for this course as of Jan. 1, 2000.
- The Preventive Health Practices course remains a one-time requirement; providers do not need to repeat the course to meet the new regulations, but you might want to do this every two or three years to stay current.
- Make sure your course completion cards for CPR and First Aid have an expiration date; otherwise, your Licensing Analyst will not know if they are current, and you will not know when you need to renew your cards.

For more information, please contact Donna Westlake at EMSA, (916) 322-4336. You may also visit the EMSA Web site at **www.emsa.ca.gov** ❖

CHP workshops coming to CAEYC

Be sure to look for the following CHP workshops at CAEYC this year. Meet the presenters who also write the newsletter articles and talk to you on the Healthline!

- **Friday, March 10, 8:30 a.m.** *How to Talk to Parents of the Child with Behavioral Problems* (Marsha Sherman and Jennifer Smith)
- **Friday, March 10, 12:30 p.m.**: *Building Relationships that Link Inclusive Practices* (Pamm Shaw)
- **Friday, March 10, 4:30 p.m.** *Proper Car Seat Installation: Demystifying the Process* (Vella Black-Roberts)
- **Friday, March 10, 4:30 p.m.**: *CalWORKs and Social Services — New Players in the Child Care Field* (Marsha Sherman)
- **Friday, March 10, 6:30 p.m.**: *Are the Health and Safety of Your Program in JEOPARDY?* (game show format, prizes) (Lyn Dailey, Terry Holybee)
- **Friday, March 10, 6:30 p.m.** *Navigating the System: California's MAP to Inclusive Child Care* (Pamm Shaw)
- **Saturday, March 11, 10:30 a.m.**: *Working with Biracial Biethnic Children – A Curriculum Guide* (Rahman Zamani and Paula Gerstenblatt)

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Child Care Health Connections
January-February 2000
Volume 13, No. 1

Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $20 per year. ***Newsletter articles may be reprinted without permission*** if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH

QUESTION:

I have been getting conflicting advice on how I can exclude a child from my program due to illness. Can you offer any advice on working with parents on this issue?

ANSWER:

As a child care provider, you render an extremely important service to the community. Your program directly impacts the lives of the children and families you serve as well as other members of the community. One very important step you can take to help ensure the success of your program is to maintain good relations with parents, neighbors, landlords and licensing personnel. Sound and enforceable health policies are an essential part of your work, not only for the health and safety of the children in your program but also for the parent/provider contract.

Some recommendations on how to achieve this goal are:

- Maintain an open line of communication with parents at all times.
- Before enrollment, explain in detail the type of child care program you operate and discuss each part of your parent/provider agreement.
- Keep an original signed copy of the agreement, and give the parent(s) a copy.
- Maintain a daily log and discuss relevant incidents with parent(s).
- Inform parent(s) of your open door policy and encourage them to visit your program.
- Schedule periodic conferences to review terms and agreements of your policies and especially your response to children's illnesses.

Keeping children healthy is a partnership between parents, child care providers, the children themselves and the medical provider. One of the most important steps you can take to ensure the health and safety of children in your care is to start the day with the *Daily Health Check*. Perform a quick health assessment of each child every day upon his or her arrival before the parent or guardian leaves. This allows you to make a judgment about what is normal for each child, rather than to diagnose an illness. It also helps identify problems early.

Make sure that you have a clear policy statement on inclusion/exclusion and that your parents receive a copy. Developing a child exclusion/inclusion policy in your program may take some effort at first but it will help you run a successful and safe business. Encourage parents to have a plan for what they will do when their child is ill and not to wait until the child becomes ill.

The Healthline has developed a one-page Health & Safety Note that specifically discusses child exclusion/inclusion in the child care environment. If you would like to receive a free copy of this document which is also available in Spanish, please call the Healthline at (800) 333-3212. ❖

Infant/Toddler issues

"Where should my baby sleep?"

by Cheryl Oku, Infant-Toddler Specialist

Q *"Where should my baby sleep? I'm at work all day but still nursing. I like the closeness of sleeping with my baby. She still wakes up several times and I can easily put her back to sleep that way. My friends say that co-sleeping works for them. But I recently heard a report that it's unsafe and babies have died this way."*

A You're not alone in being confused and perhaps alarmed by this new recommendation from the CPSC (see related article on this page) which may contradict your own experience as a parent as well as the opinions of family, friends and some professionals. While getting a good night's sleep is important, your child's safety is of utmost importance.

Please note that the study encourages mothers to ***continue to breastfeed***. However, you need to be alert to the hazard of overlying and the possibility of smothering when an infant remains in bed with you after feeding.

The study points out the hazards of entrapment and strangulation between the mattress and wall, other furniture, bedframe, footboard, headboard or side railing (including the portable side railings designed to keep children from rolling out of bed). It does not discuss the other hazards typically found in adult beds, such as soft bedding, blankets, comforters and pillows, which are associated with an increased risk of Sudden Infant Death Syndrome (SIDS).

Critics of the report say that while parents need to know about safety hazards associated with adult beds, a single report does not justify the recommendations. They note that the research methods did not thoroughly factor in the parent's alcohol or drug use, smoking or obesity. It did not compare the number of deaths to the total number of infants who actually bedshare. (Note: There are no reliable statistics on how many infants bedshare or a standard definition of bedsharing.) It studied only the information reported on death certificates, which varies by state in thoroughness and reliability.

Anthropologists say that children have always slept with parents and continue to do so in many cultures without increased risks. Though many American pediatricians have discouraged this practice in the past, some now express a different view in the belief that co-sleeping fosters bonding and facilitates nighttime breastfeeding and better sleep for parent and infant. According to the American Academy of Pediatrics, however, studies show that contrary to popular belief, co-sleeping does not reduce the risk of SIDS.

In addition, the practice of co-sleeping is gaining popularity among young working parents who don't wish to be separated from their children at night. Other factors which might lead to co-sleeping are the individual sleep patterns or temperament of the child (who may be particularly sensitive to separation or stimulation) or economic factors such as whether the family can afford a safe crib.

Of course, each parent and caregiver will have to make his or her own decision about where the baby will sleep. Use the CPSC information and recommendations to make an informed decision about where your baby will sleep safely. Call the Healthline at (800) 333-3212 for federal crib standards or SIDS information. ❖

CPSC urges that adult beds are unsafe for children under age 2

"Don't sleep with your baby or put the baby down to sleep in an adult bed," says Ann Brown, Chair of the Federal Consumer Product Safety Commission (CPSC).

Children younger than age 2 should not be placed in adult beds to sleep due to significant risks of accidental strangulation or smothering. There are 65 deaths per year of children under 2 years of age as a result of sleeping in adult beds, according to the study presented at a September news conference sponsored by the American Medical Association and published in the October issue of the Archives of Adolescent and Pediatric Medicine. In addition, an average of 50 deaths per year are linked with cribs, most of which did not meet federal standards. Each of these deaths could have been prevented by the use of safe sleeping arrangements and equipment.

Of the 515 deaths over the eight-year period studied, 121 were children were accidentally smothered while sleeping with a parent, sibling or other adult. In the other 394 deaths, children suffocated or strangled after they became entrapped in parts of the bed — between the mattress and the bed frame, headboard, footboard, the wall, other furniture or bed railings. This included both waterbeds and other types of beds. Only two deaths were reported to be related to the use of alcohol.

The authors of the report make the following recommendations to educate parents about the dangers of placing infants to sleep in adult beds:

- Children younger than 2 years of age should sleep in cribs that meet the federal safety standards and industry voluntary standard.

(continued on page 11)

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Expand your definition of quality child care

by Lyn Dailey, PHN

Over the last year, I have had many discussions with child care health consultants regarding quality child care and the limited inclusion of health and safety. They are amazed at the things they still see in widely respected, top-quality programs. Will we ever move beyond the minimal and basic health and safety requirements of licensing to something broader and more comprehensive, such as addressing the key recommendations of the *National Health and Safety Performance Guidelines for Out-of-Home Care (Caring for Our Children)?*

Responsive, developmentally appropriate care will not protect children from unsafe and unhealthy environments. A quality program must also include a level of knowledge and practice that allows and encourages children to develop to their full potential. Unsafe play equipment, poor hygiene practices, improper administration of medications, and choking hazards are but a few of the things that can place children at risk for injury and death on a daily basis.

We routinely see hot dogs cut into rounds and whole grapes served to toddlers. Preventing choking hazards is one of the most basic and long-standing safety precautions in existence, yet it is frequently overlooked. Unsafe cribs and positioning babies to sleep on their stomachs still places babies at risk for suffocation, strangulation and SIDS. Staff and children's bathrooms still exist without sinks for handwashing.

With the recent focus on quality care as a result of brain research and Children and Families First Initiative (Proposition 10) funding, it is crucial that we make sure health and safety are part of every dialogue and considered in all planning to increase quality. Many parents, providers and regulators only see licensing as the primary safeguard for child care practices and environments. There is still much work to be done, and it is up to us to point out the need for enhanced health and safety training, linking with public health services, and allocation of funding and resources for the improvement of health and safety practices in child care settings. ❖

A vision for the millennium

by Betty Bassoff, DSW

This newsletter is published under the umbrella of the Graduate School of Public Health (San Diego State University) which is a member organization of the American Public Health Association (APHA). APHA was responsible for creating the National Guidelines for Health and Safety in Child Care which we promote in every issue. Their goal for the millennium is "Health Care for All," and it's a goal we actively support. Under that goal:

- All children and their parents will have full health coverage including dental and mental health services as a right of citizenship.
- Families will choose their own health providers.
- Services will be located at convenient areas for families such as at schools and child care-linked sights, and will operate at hours convenient to working families.

Now, to paint a portrait in child care settings for the next century: All of our children will have a medical home because we helped families find the resources and services they needed to keep their children healthy. In doing so, we will create a network of Family Health Coordinators in centers, resource and referral agencies, and family child care associations across the state, targeting children and communities at risk in our initial efforts. We will be able to collaborate with our health system partners in providing on-site screenings, staff and parent education, and problem solving to reduce the gaps in support services for families. There will be a child care health consultant in every county or region of the state and our statewide health consultant network will regularly share information and strategies to improve the health and safety environment for children in out-of-home care. ***Outside of France, California will provide the best child care services for children.***

Now, let's work together to make this portrait a reality!

CHP workshops at CAEYC

(continued from page 1)

- **Saturday, March 11, 10:30 a.m.** *"I Have a Child Who ...". Supporting Children and Families by Linking Child Care Staff and Providers with Information on Health, Child Development, and Local Support Services* (Cheryl Oku)
- **Saturday, March 11, 4:30 p.m.** *What Are Early Warning Signs: Children in Trouble* (Pamm Shaw and Jennifer Smith)

Parent's page

Involving fathers in early education and child care

by Rahman Zamani, MPH, Program Analyst

It's no secret that parents' involvement in early childhood programs and schools has great impact on the development and academic achievements of young children. In the past, researchers have mainly focused on issues concerning mothers and their children and much less attention was paid to fathers. If they targeted fathers, they often focused on non-resident fathers, their payment of child support and the extent to which they visit or have custody of their children.

In recent years, men as fathers have often been the subjects of research studies. The ever-increasing child development literature has largely focused on the outcome of the father's involvement, especially during infancy and early childhood.

The meaning of fatherhood and roles and responsibilities of fathers have changed over the last several decades. There are also enormous individual, cultural, religious and social class differences associated with the positive and active involvement of men in their children's life, care and well being. Nowadays fathers, like mothers, have multiple roles and share family responsibilities as providers, protectors, nurturers, companions, disciplinarians, educators, etc.

Studies show that fathers, through appropriate interactions, can positively influence their children's social, emotional and intellectual development and well-being. A study of fathers' involvement in their children's schools, reported by the National Center for Education Statistics (NCES) concluded that children behave better and do better in schools when their fathers are involved, regardless of whether their fathers live with them or whether their mothers are also involved in their schools.

Research also shows that with the greater involvement of fathers in the lives of their children from birth, children score higher on intelligence tests. Children who have good or ongoing relationships with their fathers appear more likely to do better at school, have better self-esteem and fewer behavioral problems.

Fathers and mothers interact with their children in unique and different ways. Their roles are not equal or interchangeable, but each parent contributes to their child's development and well-being. Therefore, it's important that child care providers include both fathers and mothers in the care and education of their children. ❖

Tips for promoting fathers' involvement in early childhood programs

- *Identify fathers' needs and participation priorities.*
- *Involve both parents in activities, decision making and curriculum planning.*
- *Make your programs flexible. Men can attend if activities are scheduled outside of their regular work hours.*
- *Provide child development and parenting information. Help fathers expand their understanding of the importance of the early years in terms of children's later development.*
- *Include activities that teach fathers how to help their children learn.*
- *Display pictures of fathers and children around the school or program facility.*
- *Ask fathers to offer their skills; acknowledge their contributions.*
- *Honor cultural diversity. Invite families including fathers to your program; learn from them about their cultures and their goals for their young children.*

Research suggests that a father is more likely to be physically, emotionally and financially involved with his child if he is confident in his parenting skills and feels that he plays a role in the child's future.

Sources National Institute on Early Childhood Development and Education, National Center for Education Statistics, Beach Center on Families and Disability at the University of Kansas.

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HEALTH & SAFETY NOTES

California Child Care Health Program

RUNNY NOSE IN THE CHILD CARE SETTING

(The Snuffly Child or Green Gooky Nose)

☞ **What Is It?** The child with a runny nose and stuffiness is a familiar problem in the child care setting. The nose is lined or covered by a delicate tissue called "mucosa" which produces mucus (the sticky, slippery secretions) to protect the nose. If this tissue is irritated, it swells up, causing blockage and a lot of mucus. Sometimes children get repeated runny noses or permanent sniffles and a green nasal discharge, which are uncomfortable conditions for the child as well as child care provider.

☞ **What Causes the Runny Nose?**

1. ***The Common Cold*** is the most common cause of a runny nose and chronic runny nose. This is generally a mild illness, and the child feels and looks well otherwise. The child usually gets better on his own within a week. Runny nose is usually accompanied by mild fever. It may also go with other symptoms such as headache, sore throat, coughing, sneezing, watery eyes, and fatigue.

The child with a common cold usually gets better on his own within a week.

2. ***Allergies*** can also cause a runny nose. They usually occur after 2 years of age and after the child has had plenty of exposure to allergens (the substances that can produce allergic reaction in the body). They might occur during a specific season or after a particular exposure (e.g. to grass or animals). The allergic runny nose might also be associated with watery and itchy eyes, sneezing, asthma, rubbing of the nose and a lot of clear mucus.

With allergies, the runny nose may last for weeks or months, but there is no fever or spread of disease to others.

3. ***Bacterial infection (sinus infection)*** may occasionally develop and contribute to the continuation of illness.

   This additional infection of the common cold tends to cause yellow-greenish mucus and sometimes pain that continues for more than 10 days.

Remember that yellow or green mucus does not mean that a child has a bacterial infection. It is normal for the mucus to get thick and change color as common viral cold progresses.

☞ **Is Green Mucus More of a Concern than Clear Mucus?** In most cases green nasal mucus (usually found toward the end of the cold) is **not** more contagious than clear mucus and may even be **less** contagious. The runny nose usually starts with clear mucus and then becomes whitish or greenish as the cold dries up and gets better, (as the body mounts its defenses against the virus, the white blood cells enter the mucus and give it the green color). Usually the green mucus is in smaller amounts and thicker, a sign that the cold is "drying up" and ending.

Green runny nose that lasts for more than 10-14 days, and that may be accompanied by fever, headache, cough, and foul-smelling breath, might be a sign of sinus infection. The child should have a medical evaluation and may need antibiotic treatment.

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(Runny nose continued)

☞ **When Are Children Contagious?** The amount of virus present is usually highest 2 to 3 days *before* a person develops symptoms of the illness and continues to be present for 2 to 3 days after symptoms begin. As a result, infected children already spread viruses before they begin to feel ill.

☞ **If Infected, How Is the Infection Spread?**
If infected the child may spread the germs to others by:

- Wiping a nose with their hand and then touching people and objects
- Provider wiping children's noses and not washing hands
- Sharing of mouthed toys by infants and toddlers
- Coughing and sneezing into the air
- Kissing on the mouth
- Poor ventilation

☞ **How Can We Limit the Spread of Infection?**

To prevent the spread of infection from respiratory illnesses and runny noses, follow routine healthy practices:

- Avoid contact with mucus as much as possible.
- Make sure that all children and staff use good handwashing practices especially after wiping or blowing noses; after contact with any nose, throat or eye secretions; and before preparing or eating food.
- Do not allow food to be shared.
- Clean and disinfect all mouthed toys and frequently used surfaces on a daily basis.
- Wash eating utensils carefully in hot, soapy water; then disinfect and air dry. Use a dishwasher whenever possible. Use disposable cups whenever possible.
- Make sure that the facility is well ventilated, children are not crowded together, especially during naps on floor mats or cots. Open the windows and play outside as much as possible even in the winter.
- Teach children to cough and sneeze into their elbow, wipe noses using disposable tissues, throw the tissue into the wastebasket, and wash their hands.

☞ **When Should the Child Stay Home?**
Exclusion policies should be based on your general illness policies, not merely the color of the mucus. For example, you might decide to exclude any child who is too sick to participate, no matter what the cause or color of the discharge.

Excluding children with runny noses and mild respiratory infections and colds is generally not recommended. As long as the child feels well, can participate comfortably and does not require a level of care that would jeopardize the health and safety of other children, she can be included.

Exclusion is of little benefit since viruses are likely to be spread even before symptoms have appeared.

☞ **When Should the Child Be Sent Home or Seen by a Health Provider?**

- When a child looks sick, has a rash, has a fever (oral) over 102 degrees for ages 2 and up or has a fever (taken under the arm) of 101 degrees or higher for ages 4 to 24 months, or has difficulty breathing or seems to be in pain
- Earache and/or pulling at ears, which might be accompanied by fever and fussiness (sign of ear infection)
- Redness, sores and crusting of the skin around the nose and mouth
- Infants, especially under 4 months of age, not getting better in a couple days or getting worse

References: Healthy Young Children, A Manual for Programs, 1995 Edition, Keeping Kids Healthy, Preventing and Managing Communicable Diseases in Child Care, Preliminary Edition, The ABCs of Safe and Healthy Child Care, A Handbook for Child Care Providers, published by CDC.

Rahman Zamani, MPH (8-19-98)

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Behavioral health

Naptime for young children

by Jennifer Smith, MA, Mental Health Consultant

When I worked in the classroom with young children, I remember how challenging it was when a child had difficulty napping. It was difficult for other children to settle down and fall asleep, and it was stressful for the staff. Here are some factors that might help children and staff in your program have a smoother naptime experience.

Importance of Routine. Consistent routines allow children to predict what happens next, giving them a sense of security, comfort and trust. Naptime is part of your daily routine and should occur at a regular time every day, with consistent, age appropriate expectations. Some things to consider are:

- Does this child have a consistent daily routine in general?
- Is this child new to your program/classroom?
- Have you talked with this child's parents regarding his or her sleep routine at home? (i.e. Is her sleep schedule regular? Does the child sleep with a special animal? Does he or she like tummy rubbing or patting when falling asleep?)
- Is this child experiencing a separation issue? (Sleeping can be a reminder of home and trigger the child's sadness. A small, special object from home that the child can hold while sleeping may help.)
- Is this a time of particular stress at home?

Naptime as a Transition. Young children experience many transitions throughout the day and need our help preparing for these changes. By naptime, children have already accomplished several transitions in their day (said goodbye to parents, played indoors, outdoors, eaten a snack, etc.). Some things you can do are:

- Understand the child's ability to make transitions (temperament styles, activity level, sensitivity to stimulation, intensity of reactions)
- Provide developmentally appropriate "transition activities" before naptime (reading a calming story to the group, giving children time to sit quietly and look at books, play soft music or a story tape)
- Plan naptime *before* outside time. Children are too energized by what happens directly before naptime.

Most of us have sleeping preferences. We prefer a certain pillow or sheets. Some of us can sleep in the car or on the plane while others can't sleep anywhere but their own bed. Young children also have their own individual sleep needs and preferences. Observing, asking and thinking about what might work for that one child at naptime will help everyone rest easily. ❖

Diversity

Providing culturally sensitive child care environments

by Paula Gerstenblatt, MSW

In order to provide a culturally sensitive environment inclusive of biracial/biethnic children, child care providers need to have resources and materials that reflect the experiences of biracial/biethnic children and families. This includes books, pictures, resource materials and activities sensitive to family members of different racial or ethnic backgrounds. If multicultural materials and activities do not address the needs of biracial/biethnic children, they can be adapted.

At holiday times, some children may celebrate more than one holiday in their family and family traditions may vary when combining more than one culture in the home. Asking family members how holidays are celebrated, if any, in the home will provide you with important information for the child care program so as not to exclude any child. If possible, ask family members to share their experiences and family traditions which may vary from families who celebrate the traditions of just one culture. This is enriching for all children in your program.

When young children are exposed at an early age to diverse groups of people and cultural practices, they become increasingly comfortable with differences and can view them as positive and natural. One provider I recently spoke with has several biracial/biethnic children and children from diverse racial and ethnic backgrounds in her program. She remarked that most of the children had been with her since infancy, and the racial and ethnic diversity in her program was a natural part of life.

However, if your program is not as diverse, you can still provide an inclusive, culturally sensitive environment with materials, activities and books. Many more selections are available now than in the past. As part of our Diversity Research and Training Project, we have compiled a bibliography of books about biracial/biethnic children by developmental stage, from young children to adults. We have online resources and videos, a resource list for families, and a recently developed curriculum and training model for child care providers. Please call me at (510) 281-7914 if you have questions. ❖

Inclusion insights

Discussing provider concerns with parents

by Pamm Shaw, Disabilities Specialist

One of the most difficult tasks for child care providers is to communicate concerns they may have about a child to the parents. This is especially difficult if there are behavioral challenges involved. Here are some tips to help providers work with the families of children in their care.

It's about the relationship. Talk to parents regularly. Mutual trust and respect must be established between the parent/family and provider in order for the parent to "hear" concerns. It is important to check how and what the child does at home since the expectations of group care may be different.

It's about communication. *How* you communicate concerns to families is more important than *what* you communicate. Don't *assume* anything. Ask questions. Be sensitive to cultural issues, the child's temperament, his/her experience in a group care setting, age of child, health history and other factors that may influence a child's behavior.

Families may not be familiar enough with child development to know when a child is not within the "typical" range. Providers can use *Early Warning Signs* or other written materials to describe specific behaviors.

People give and receive information in different ways. Communication is a complex business, and there are many opportunities for misinterpretation. Providers should be clear, and *always* find something positive to share about the child. It is important to be honest and let the parents know that resources are available.

It's about knowing the system and resources. If the provider feels the child would benefit from special services, let the parent know that assessment is *free* and refer the family to the local school district, Regional Center or Family Resource Center. Testing can be done in the child care setting and providers should encourage families to request this.

Providers can learn the system by knowing the rights of families and children and by helping families get what they need.

It's all about collaboration. Providers can contact programs and agencies that provide services for children with special needs. Collaborating with other service providers is a good way to provide comprehensive services at the child care site and make the referral and assessment process less painful for the family.

Building relationships takes time, energy, understanding and commitment, but that's what it's all about. Listen to families. Be there for the child. Show you care. ❖

Legislative update

by Marsha Sherman, CCHP Director

The Child Care Health Linkages legislation, **AB561** (Romero), is still alive and well. We are working to make sure that funds are in the budget to implement the legislation. We also want to assure its passage in the Senate (it has already been approved by the State Assembly), so keep writing letters to your local Senator.

In addition, we can still use your help writing letters to the Governor and calling him (916/443-7511) or the Office of Education (916/323-0611) stressing the following:

- The legislation will create an infrastructure that bridges the gap between existing services and the needs of children and families in child care.
- Child Care Health Linkages needs a statewide approach.
- Linkages is definitely *not* a duplication of services. ❖

Health and safety calendar

February

16-17: 10th Annual Local Child Care Planning Conference presented by the Child Development Policy Advisory Committee. Sacramento. (916) 653-3977

23-25: 2,000 for 2000: Statewide Latino Health Conference, Sacramento. Latino Coalition for a Healthy California. (415) 431-7430, ext. 108 or visit **www.lchc.org**

March

9-11: CAEYC 23rd Annual Public Policy Symposium and Annual Conference, Sacramento. (916) 442-4703 See the list of CHP workshops on page 1.

22-24: California Child Development Administrative Association Conference, San Diego. Contact Tammy Kyle at (562) 427-8834 or Deborah Slobojan at (626) 854-3449.

24-26: Child Care Is the Building Block of the Future 2000. Napa. California Association for Family Child Care. (510) 658-2449.

Choosing the right child safety seat for your older child

by Vella K. Black-Roberts, MPH, RD

Do you know the age when most children fit properly and safely into a regular safety belt? Researchers say it's age 8 or older, but children usually outgrow their safety seats when they reach 40 pounds at age 3 or 4. What should you do about a child safety seat when your child weighs more than 40 pounds?

Although current California law does not require that a child over age 4 and 40 pounds ride in a child safety seat, a poorly fitted seat belt may put your child at risk for injury or death. There are no conventional child safety seats with harnesses certified safe for use by children over 40 pounds. However, children should never be moved from a convertible child safety seat to a safety belt alone.

If the child is mature enough to sit still with a lap/shoulder belt, a belt-positioning booster seat is the next step. Keep in mind that these seats are designed for children ages 3 to 4 and at least 40 pounds who are unable to fit safely in a convertible seat. (There are special harnesses for younger children and wiggly children over 40 pounds.)

When selecting a booster seat for a child weighing more than 40 pounds, you need to consider which type is best for your child and fits in your vehicle (car, truck or van). Choose a high-backed model if your child often falls asleep in the vehicle or sometimes rides in a vehicle with a low seat back. If the vehicle's seat supports the child's head, consider using a backless booster. It may fit the seat better, and there are special head-positioning pillows for improved comfort. The maximum weight limits for booster seats range from 60 to 100 pounds, so be sure to look for a wide or adjustable base if the child is short and stocky.

Remember, most children need to use a belt-positioning booster until they are at least 8 years old, depending on the child's height and where the seat belt is attached to the vehicle. The lap portion of the belt fits snugly on the upper thighs or hips. The shoulder belt fits across the center of the chest and *not* across the child's face or neck.

To learn more about how to properly install child safety seats, contact your local county public health department, Child Passenger Safety Coordinator or the Healthline at (800) 333-3212. For a list of booster seats available, call SafetyBeltSafe at (800) 745-SAFE. ❖

Obesity: A growing problem among young children

by Vella K. Black-Roberts, RD, MPH

The number of overweight children in this country has more than doubled in the past 20 years, according to the United States Department of Health and Human Services. Researchers say obesity among our children is more prevalent today despite three decades of generally improved health for the nation's children. Experts say there can be a number of reasons for this including:

- Heredity, environment, socioeconomic-familial patterns and demographics
- Lack of physical activity and high levels of inactivity
- The composition of the diet (calories from fat appear to be stored as fat more easily than calories from other sources)
- Slower metabolism, which is largely inborn, but may be influenced by such factors as repeated attempts at weight loss or the number of daily meals

While the causes can be many, inactivity and dietary factors are considered two of the most common. Many studies have documented the substantial increase in non-physical activity by American children. Television, which accounts for some 24 hours of our children's weekly time, is one of the primary culprits.

The case of a 10-year-old child helps illustrate the point. She was obese when she moved to live with her father. Despite years of not being able to lose weight, once she moved with her father to the country, she was able to lose weight. According to this child, her weight loss wasn't due to a very low-calorie diet or illness, but increased physical activity. Her motivation, she said, was from the poor quality of television programming available in her new home.

Activities such as kickball, baseball, softball, skating, running and playing outdoors should be substituted for television watching or playing video games. However, more physically demanding activities without more nutritious foods and family-based behavior management would only solve part of the problem. Child care providers and schools have improved their meals through participation in the USDA National School and Child Care Food programs, both of which advocate and promote healthier eating and its benefits, but the

(continued on page 11)

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- Children younger than 2 years or children with disabilities that restrict their movement should not be put to sleep in adult beds (especially waterbeds) that present a risk of entrapment between the bed mattress and a wall, headboard, footboard, side railings or adjoining furniture.
- Children younger than 2 years or children with disabilities that restrict their movement should not be put to sleep in adult beds with railings (headboard, footboard, or side railings) that present a risk of strangulation by head entrapment.

References: Suad Nakamura, PhD; Marilyn Wind, PhD; Mary Ann Danello, PhD. *Review of Hazards Associated with Children Placed in Adult Beds*. Archives of Pediatrics and Adolescent Medicine. Vol. 153, No. 10, October, 1999. ❖

Obesity

(continued from page 10)

evidence shows our children are still consuming total fat and saturated fat in higher quantities.

Consequently, the food choices of most American children do not meet the recommended intake of food groups and choices described in the Food Guide Pyramid, especially fruits and vegetables. The following is a partial list of guidelines that child care providers and families can use to help ensure their children are eating right.

- Enjoy a wide variety of nutritious foods from the Food Guide Pyramid, including foods containing iron and calcium (*iron*: meat, chicken, beans, prunes; *calcium*: milk, fortified soy milk, cheese, yogurt, kale).
- Eat plenty of bread and cereals, vegetables, legumes and fruits, and drink water as a beverage. Also offer milk and juice with meals.

Encourage physical activity which can involve the entire family. Incorporate these changes into all parts of your program while decreasing caloric intake by limiting — not eliminating — sweets and treats. Limit television time; television viewing and video games are not a form of physical activity. In addition, food advertisements found on television, which are aimed specifically at children, are often contrary to recommended healthful eating practices. ❖

Update on the California Children and Families Commission (Prop. 10)

by Pamm Shaw, Coordinator, California's MAP to Inclusive Child Care

If you are not yet aware of your local community's Prop 10/Children and Families Commission, call your county supervisor or your resource and referral agency to find out. Get on their mailing list. Provide input at local meetings.

The State Commission has approved the guidelines for County Commissions. County groups should be in the process of developing and completing strategic plans. Funds have been distributed to counties and range from $150,000 to millions of dollars for early childhood services. A statewide media campaign will begin Jan. 1, 2000. *Welcome Baby* kits will be given to every child born in California with resources and information for families. Some of the plans for the use of local Prop. 10 funds include: home visiting programs, child care subsidies to increase staffing and salaries for providers, and consultation and support services for child care providers and families.

It is critical for child care providers to speak up now. Prop. 10 funds offer communities the opportunity to really make a difference in the lives of young children and their families. At this time, Prop. 10 is being seriously threatened by tobacco groups that wish to overturn the measure. They have succeeded in getting a recall vote on the March 2000 ballot.

If you care about children, please let your families and constituents know how important these dollars can be. The entire country is looking to California's efforts to increase funding and services through these dollars. Let your voice be heard in support of Prop. 10: Children and Families come first! ❖

Product watch

Bungee Baby Bouncers by E and I Inc. are being recalled because knots tied in the black rope that supports the bouncer can unravel, causing the baby to fall. Consumers should immediately stop using the bouncer and return the bungee assembly to E and I Inc. for a free repair. For more information, call E and I Inc. at (800) 853-6001.

Stairway gates by North States Industries Inc. have been recalled because the locking mechanism can release when the gate is shaken. Consumers should stop using these gates immediately and return them to the store where purchased for a full refund. Call North States Industries Inc. at (800) 848-8421.

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Access to Health Insurance and Health Care for Children in Immigrant Families is a free document published by the UCLA Center for Health Policy Research. Available online at **www.healthpolicy.ucla.edu** or call (310) 825-5491.

The Community Resource Guide for Lead Poisoning Prevention is a manual for lead poisoning advocates, parents and community groups available free from the Western Center on Law and Poverty. Call (213) 487-7211, ext 20.

Confronting Asthma in California's Latino Communities explores the growing asthma problem among the Latino population. Get your free copy from the Latino Issues Forum at (415) 547-7550, or **www.lif.org**.

Selecting Culturally and Linguistically Appropriate Materials: Suggestions for Service Providers is available from ERIC Clearing house. Call (800) 583-4135, e-mail to ericeece@uiuc.edu, or visit **http://ericeece.org**.

Online resources

Common Sense About Kids and Guns is a public education organization dedicated to motivating parents, and all adults, to take positive action to protect children from gun-related deaths and injuries. Visit **www.kidsandguns.org**.

Funding opportunities for child care programs: The National Child Care Information Center's Web site at **www.nccic.org/faqs/funding.html** contains links to federal funding programs.

Funding opportunities for after-school programs: Visit the Department of Education's new Web site at **www.afterschool.gov** for information on federal funding resources that support children and youth outside school hours.

Fathers who provide child care can find helpful resources at **www.parentsplace.com** or **www.slowlane.com**.

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Child care health consultation: The view from the health department

by Judith A. Calder, MS, RN, Public Health Nurse, Alameda County Health Services

It's very satisfying to work as a Public Health Consultant to the child care community of Alameda County in a health department that values child care enough to create the position. Promoting health in the child care setting improves the health of children, parents and staff, and involves working with various community groups to achieve this end. It's very appropriate that this function reside in a health department and within the department of Maternal, Child and Adolescent Health (MCAH). The creation of this position is a new and welcome trend in some health departments across California and the country.

Health care services and child care services depend upon one another to support the healthy and optimal development of children and families. Child care programs depend on quality health information and standards which prevent disease and injury, and which support assessment, early intervention and the inclusion of children with different abilities. Health services depend on child care programs to deliver their health promotion message and activities. This includes improved immunization rates, routine preventive health care from a health provider (medical home), and health education for children, parents and staff on a wide variety of topics such as dental health, early prenatal care, car passenger safety and environmental health.

Accomplishments in Alameda County so far include: collaboration with the California Child Care Health Program to develop and expand a Child Care Health Advocacy course offered through the community colleges, and linkage with Behavioral Health Services to create a mental health consultation service to child care programs. There has been good use of the phone consultation and health education classes by child care

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Are child care providers affected by Assembly Bill 1978?

Assembly Bill 1978, which went into effect Jan. 1, 2000, mandates that certain food facilities have an owner, manager or employee pass a food safety certification examination. Home-based and center-based child care providers *do not* have to do this. However, child care providers are encouraged to stay current with food safety handling and practices to ensure the quality of the food they serve.

The law does impact restaurants, cafeterias, bars, bakeries, most markets, commissaries, mobile food preparation units (catering trucks), and stationary mobile food preparation units (food trailers).

For more information, contact the Environmental Health Services division of your local Health Care Services Department, or call the Child Care Healthline at (800) 333-3212.

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Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:

www.childcarehealth.org

Ask the nurse...

by Deb Thompson, RN, MPH

QUESTION:

Both my husband's parents are smokers, and I am concerned about going on vacation with them this summer as we have a 3-month-old baby. Could you tell me more about secondhand smoke from cigarettes and how it can affect my baby?

ANSWER:

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe or cigar, and the smoke exhaled from the lungs of smokers. This mixture contains more than 4,000 substances, more than 40 of which are known to cause cancer in humans or animals and many of which are strong irritants. Secondhand smoke is also called environmental tobacco smoke (ETS), exposure to secondhand smoke is called involuntary smoking, or passive smoking. The U.S. Environmental Protection Agency (EPA) has classified secondhand smoke as a known cause of lung cancer in humans. Passive smoking is estimated by the EPA to cause approximately 3,000 lung cancer deaths in nonsmokers each year.

Secondhand smoke can be a serious health risk to children and their developing lungs. Infants and young children whose parents smoke in the home are among the most seriously affected by exposure to secondhand smoke, being at increased risk of lower respiratory tract infections such as pneumonia and bronchitis. Some studies have shown that passive smoking is responsible for between 150,000 and 300,000 lower respiratory tract infections in infants and children under 18 months of age annually, resulting in 15,000 hospitalizations each year in the U.S. These same children are also more likely to have reduced lung function and symptoms of respiratory irritation like cough, excess phlegm (mucus) and wheezing. Asthmatic children who are exposed to secondhand smoke are especially at risk as these children appear to have an increased number of asthmatic episodes, and their symptoms are more severe.

What you can do to reduce the health risks of passive smoking in the home:

- *Don't smoke, or permit others to do so, in your house or car.*
- *If a family member insists on smoking indoors, increase ventilation in the area where smoking takes place. Open windows or use exhaust fans.*
- *Do not smoke if children are present, particularly infants and toddlers. They are particularly susceptible to the effects of passive smoking.*
- *Don't allow babysitters or others who work in your home to smoke in the house or near your children.* ❖

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Infant/toddler issues

Baby's brain development and quality child care

by Cheryl Oku, Infant Toddler Specialist

Parents and caregivers today are more aware than ever of the importance of the first three years for their child's brain development. Television programs, magazines and news reports bring us the findings from new and exciting brain research. Books, toys and programs for boosting baby's brain power abound.

Now that so many of our infants and toddlers are in child care, parents and caregivers are asking whether our youngest children are receiving the nurturing and enrichment necessary for optimal brain development. Research shows that quality child care builds healthy brains and healthy children.

Quality care also supports the close relationships between a child and caregiver critical to healthy development.

What are the indicators of quality child care for infants and toddlers?

- *A primary caregiver* who provides consistent nurturing
- *Small group size*, where the caregiver can be more responsive to each child
- *Continuity of care*, which encourages secure, predictable relationships
- *Low staff turnover*, which prevents stress over changing caregivers
- *Trust and good communication between parents and caregivers*, which lead to consistency between home and child care
- *Staff training*, which leads to higher quality care, as well as clean, safe and stimulating environments

How is a baby's development affected by the quality of care?

- *Language and thinking skills*: Children involved in conversation and exposed to lots of talking, singing and reading develop the parts of the brain that handle language. These are less likely to develop when the group size is large or caregivers change constantly. Problem solving and higher thinking skills are also dependent on both rich experiences and close relationships.
- *Physical skills*: Children need opportunities to crawl, climb, walk, throw and splash to develop the part of the brain which controls movement. When children are confined, they do not get the exercise needed to develop neuron connections, and motor development is delayed.
- *Emotional control*: Children raised with changing caregivers and inconsistent routines are more stressed, anxious and impulsive. They may become less caring towards others and lack social problem-solving skills and emotional control as they grow older.

Knowing the huge impact of early experiences on brain development, child care providers and advocates must work to improve our practices to implement all the indicators of quality care. ❖

Are you caring for mildly ill children?

by Gail Gonzalez, RN

Do you need a special license to care for children with mild illnesses? No, you do it every day for children who are routinely in your care.* A mild illness is a slight departure from the normal state of health. A child with a runny nose, a sunburn, a low grade fever, an upset stomach, cough, or hives from allergies has a mild illness. The younger the child, the more frequent the illnesses. It is a normal part of development, so it is a normal part of child caring. It's what you should be doing, to a point.

A child who has a special need, even for one day, will need a little more of your time and attention. You must ask yourself in each instance, "Is it dangerous to this child to be here?" (Will it make him more ill? Does he need more care than I know how to give? Does he need more time than I can provide?) and "Is it a danger to the other children?" (Does she have a contagious and serious disease? Will caring for her cause me to leave the others unsupervised or unattended?) If you can answer "No" to these questions, then you can safely care for that mildly ill child.

The secret to success is taking the time to make a plan with the parent for that child's care. You will need to know:

- Has the child seen a medical provider and is there a diagnosis?
- What can the child eat or not eat?
- How much or how little activity can he tolerate?

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** If you are providing a special place only for sick children, then you do need a special license.*

public Health

We're all in it together. by Lyn Dailey, PHN

Overwhelmed by recommendations? Here's how to get started

by Lyn Dailey, BSN, Public Health Nurse

Child care directors, health and safety trainers, and child care health consultants are well aware of the pained and overburdened looks on the faces of participants in their workshops when they talk about health and safety standards. Meeting the "Gold Standards" set by the American Academy of Pediatrics and the American Public Health Association without the staff and budget to do so can be daunting. But don't let that stop you from getting going now. Start with the following:

Get a copy of the January-December 2000 Recommended Childhood Immunization Schedule. Every licensed child care program must determine if children are up-to-date on their shots before they can be enrolled or remain enrolled. You need the most current schedule in order to do this. Make sure all staff who assess immunization records know how to use it, and get training for them if they don't. Call your health department immunization coordinator to request a copy or to inquire about training.

Post a fresh, new handwashing poster above each sink. If you can't find a new and different version, copy your old one onto brightly colored paper. People become immune to the same old thing they have looked at for months or years. Proper handwashing is the single most effective thing you can do to reduce the spread of illness in your environment.

Ask every family to complete a new emergency contact form. Don't assume that children have the same pediatrician or dentist from one year to the next, or that they still have health insurance. Check, phone numbers, job changes and emergency contacts. Call your health department for a brochure listing available health insurance plans and distribute it to every family. While you're at it, update any special care plans for children with special needs, such as asthma or food allergies.

Place a Poison Control sticker on each phone in your facility. Call (800) 582-3387 to order stickers. Make sure any existing stickers have the newest phone number: **(800) 876-4766**. If you use a cell phone, make sure you know the number to dial in an emergency because 9-1-1 may not work. ❖

The Food Guide Pyramid and you

by Vella Black-Roberts, MPH, RD

What foods should I serve the children I care for? How much should I serve each child? Am I doing all I can to promote the healthy growth and development of children in my program? Could I do more to help prevent potential health problems? These are valid questions hard-working child care providers are asking.

To help provide the answers, the United States Department of Agriculture (USDA) and the Center for Nutrition Policy and Promotion have introduced a colorful new publication, *Tips for Using the Food Guide Pyramid for Young Children 2 to 6 Years Old*. It presents healthy eating tips by encouraging food choices for a healthy diet through exercising patience, planning, being a good role model, being adventurous and being creative. The guide was developed to reflect the nutritional needs of young children and to help families and child care providers serve nutritious foods in a balanced manner, noting portion sizes and variety.

Child care providers who participate in the Child Care Food Program (CCFP) must follow the CCFP meal pattern requirements for reimbursable meals. The meal pattern shows what kinds of foods they should serve and how much equals a minimum serving.

The food guide's message to serve healthy foods has not changed since 1992, but the pyramid has. The new pyramid shows:

- Foods that are commonly eaten by children ages 2 to 6 years, drawn in a realistic style;
- Active children to stress the importance of physical activity for healthy living and play;
- Foods in single-serving portions, when possible, emphasizing eating a variety of foods and portion sizes determined by the age range of the child;
- The number of servings for food groups as a single number rather than a range to simplify planning. (A 2- to 6-year-old will need a daily total of four servings of ½ cup each from the milk group.)

For more information on how to use Tips of the Food Guide Pyramid or to obtain copies, contact the USDA at (415) 705-1336, or the Child Care Healthline at (800) 333-3212. ❖

Drowning is preventable

by Jennifer Rogers, MPH, CHES, Graduate School of Public Health, SDSU

Spring and summer are filled with fun and adventure for children of all ages. Unfortunately, it is also a time filled with injury and death from drowning. Two-thirds of all drownings occur between the months of May and August. With this in mind, it is important to know how to prevent childhood drownings in the months that lie ahead.

Drowning is the leading cause of accidental death among children 1 to 2 years of age in California. In 1997, 70 children ages 1 to 4 were killed in drowning incidents throughout the state. Drowning is such a dangerous threat to children in this age group because of their natural curiosity, exploratory behavior and inability to understand danger. Drowning is silent and rapid, with brain damage occurring in only three to five minutes.

Most drownings among children ages 1 to 4 occur in residential swimming pools, but a drowning can occur in just a few inches of water. Small children are top-heavy and tend to fall forward and head first when they lose their balance. Once they are submerged in water, they are unable to pull themselves out because they lack the proper muscle development in their upper body.

Drowning can occur in just a few inches of water.

A brief lapse in supervision is a common factor in most drownings. Of all young children who drown, 75 percent are missing from a caregiver's sight for *less than five minutes*.

As a child care provider, it is necessary to create an environment that promotes water safety. This includes communicating drowning prevention efforts to parents and other caregivers. Involving parents is crucial in prevention because the majority of drownings in this age group occur in the family's pool or the pool of a relative or friend. You can help prevent drowning by teaching children water-safety behaviors and by inviting an expert to your home or facility to teach parents how to perform CPR. Working together with parents can help create a safe and happy summer for the children you care for.

For more information on ways to prevent childhood drownings, including handouts, please contact the Healthline at (800) 333-3212. ❖

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Drowning Prevention Tips

- *Always provide careful and constant supervision of children in your care.*
- *Never leave a child alone in or near a body of water (tub, shower, toilet, pool, or a bucket of water, a creek, river or irrigation ditch).*
- *Pools should be enclosed by a fence that is at least 5 feet high. The fence should have a gate that is self-closing and self-locking.*
- *Keep climbing equipment, chairs and tables away from pool fences. All windows of the home which have access to the pool area should be screened securely.*
- *If any container is used to hold water, empty the contents immediately after use and store out of children's reach.*
- *Latch toilet seat covers when not in use.*
- *Do not keep toys in or around the pool area.*
- *Supervise children in water, even if they have had swimming lessons or are wearing flotation devices. These do not eliminate the risk of drowning.*
- *Teach children water-safety behavior (no running in or around the pool area or going near a pool without an adult).*
- *Babysitters and guardians should always be instructed about potential water hazards.*
- *Keep a telephone with emergency numbers near the pool area.*
- *Anyone caring for children should learn CPR.*

HEALTH & SAFETY NOTES

California Child Care Health Program

Anemia, Lead Poisoning & Child Care

Childhood Lead Poisoning

Lead poisoning is the most common environmental disease affecting children in our country today. While some lead naturally occurs in the earth's soil, our bodies have no use for it: in fact, it is toxic in any amount in our bodies. We have released lead into our environment by adding it to gasoline, paint, pottery and some industrial processes. Homes and buildings built before 1978 will almost certainly contain some lead-based paint.

Lead poisoning can cause serious health problems for children. It can slow their growth, cause learning disabilities and behavioral problems, and damage major organs such as the kidneys and brain.

Children between the ages of one and six years are most at risk for lead poisoning. Because young children often put their hands and toys in their mouths, they can swallow lead that gets on their hands and toys from dust, dirt and chipping paint.

Lead-based paint is not the only source of lead inside homes and child care programs. Lead can also be found in common household items such as pottery, home medical remedies, cosmetics, imported food products and candies, cans with lead-soldered seams, toys, mini-blinds and other products made of vinyl.

Children at risk for lead poisoning should have a blood lead test. This is the only way to find out if a child has lead poisoning. We don't really know how many children are lead poisoned because so few children are tested. However, all insurance plans pay for the test.

PARENTS CAN ASK THEIR CHILD'S MEDICAL PROVIDER TO PERFORM A BLOOD LEAD TEST.

CHILD CARE PROVIDERS CAN TEST THEIR PROGRAM FOR PAINT AND PRODUCTS CONTAINING LEAD.

Source: Childhood Lead Poisoning Prevention Branch
California Department of Health Services

✓
Lead poisoning can cause anemia.
✓
Anemia makes it easier for lead to get into the blood.
✓
Lead poisoning and anemia are both detected by a blood test.
✓
Lead poisoning and anemia are both preventable.
✓

PRACTICE GOOD NUTRITION AND PROPER HANDWASHING TO HELP PREVENT LEAD POISONING AND IRON DEFICIENCY ANEMIA.

Iron Deficiency Anemia

We need iron to keep our blood strong. Low levels of iron in a child's blood can make the child pale, tired, cranky, eat poorly, get sick more easily, get more infections, and have trouble learning.

Iron is a mineral found in some foods. Eating foods that are high in iron can help keep children healthy and feeling well.

Dairy products like milk, cheese, yogurt and ice cream are very low in iron. They are good for bones and teeth because they have a lot of calcium, but drinking too much milk can contribute to anemia. The milk fills the child up and he or she doesn't eat enough food high in iron. Babies should be weaned from the bottle by about 1 year of age. At this age, they should drink only 2 to 3 cups of milk per day (16 -24 oz).

Infants and children should have their blood tested for iron-deficiency anemia. Anemia can be prevented and mild cases can be reversed by eating diets high in iron.

Vitamin C helps the body use iron, so combine foods high in iron and vitamin C in meals and snacks.

SOME FOODS HIGH IN IRON
beef, pork, liver, fish cooked beans, tofu,
iron-fortified cereals, enriched tortillas & breads,
leafy greens, dried fruit, prune juice

SOME FOODS HIGH IN VITAMIN C
broccoli, cabbage, cauliflower,
tomatoes, potatoes, bell peppers
oranges, melon, strawberries

SERVE CHILDREN FOODS HIGH IN IRON AND VITAMIN C, AND COOK IN IRON POTS.

Source: WIC Supplemental Nutrition Branch,
California Department of Health Services

California Child Care Health Program • 1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

HEALTH & SAFETY NOTES

California Child Care Health Program

TYPES OF VEGETARIAN DIETS

The food preferences of the children and families you will be caring for will vary. To help you provide nutritious meals for your children and to help educate their families, we have prepared the chart below. The chart highlights different types of vegetarian diets and foods which you may need to add to provide good nutrition.

	FOODS EATEN				
Types of Vegetarian Diets	**Beef & Pork**	**Fish & Chicken**	**Milk & Milk Products**	**Eggs**	**Vegetables, Fruit, Breads, Cereals & Nuts**
Semi-vegetarian		*	*	*	*
Lacto-ovo-vegetarian			*	*	*
Ovo-vegetarian				*	*
Lacto-vegetarian			*		*
Vegan (total vegetarian)					*

Special notes:

- Children on vegetarian or strict vegetarian diets need more food than non-vegetarian children because their diets are high in fiber and low in fat and calories.
- Children who are on diets that exclude eggs, milk and dairy products may be consuming meals that are nutritionally lacking. They may need more protein, calcium, iron, zinc, vitamin D and B12, essential fatty acids (EFA) and riboflavin.
- Children on vegetarian diets may need more servings from the food groups they consume than other non-vegetarian children of the same age.

Meal Planning Tips for Vegetarian Children

- Use soy or rice milk and/or formula fortified with vitamin D and B12.
- Use cooked, dried beans, nuts, nut butters and seeds as meat alternatives to increase the protein in the meal.
- Tofu can be a good source of calcium, but only if it is made with calcium sulfate – check the label.
- Corn tortillas (made with lime) are a good source of calcium.
- Greens such as kale, bok choy and collards are also high in calcium.
- Calcium-fortified orange juice or soy and/or rice milk are other sources of calcium.
- Serve foods rich in vitamin C at meals to enhance the absorption of iron.
- Children may require more frequent meals and snacks than the typical Child Care Food Program (CCFP) meal schedule.
- Vegan meals are usually filling but low in calories.
- Consider serving eggs and dairy products to very young children or children who are picky eaters and not growing well. Be sure to obtain parental approval first, of course.
- Combining legumes, seeds, or nuts with grains can provide a good protein source.

References: Healthy Young Children, National Association for the Education of Young Children, 1991, and Meals without Squeals, Child Care Feeding Guide and Cookbook, 1997, Christine Berman, MPH, RD and Jacki Fromer.

By Vella Black-Roberts, RD, MPH,
(January 20, 2000)

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Behavioral health

Rainy days are here again...

by Jennifer Smith, MA, Mental Health Consultant

Oh, those rainy days! Kids with runny noses, wet clothes, exhausted, harried parents and the gray gloom outside. I remember staying up late on many nights to listen to the news and find out what the weather might bring the next day. When you work with young children, the rain can create havoc. However, there are some strategies that can help both you and the children you care for on these cold, wet days.

Be flexible. On rainy days, allow yourself to deviate somewhat from the normal routine. If the rain lets up an hour after your regularly scheduled outdoor time, go outside and then rearrange your day a bit. However, if it's raining and the children are playing well and engaged in their activities indoors, you may want to extend their playtime before transitioning to snack. Allow yourself and the children some room for doing what works for the moment.

Incorporate more movement activities. Children's energy gets pent up when they don't have the opportunity to run around and play outside. Try doing more gross motor (large muscle movement) activities indoors so they can work off some of that energy. You may want to have a music time that allows for jumping or moving, maybe catching bean bags or throwing scarves. You may also want to have large pillows, cushions or boxes available for them to build with or plop down upon.

Keep it simple. Rainy days are probably not the best time to try a new art activity or introduce a new set of blocks, even if that is what you had planned that day. Use materials with which the children are familiar and which seem to keep them interested and soothed. You may even want to try playing the naptime tape during indoor time to let the soothing music help keep things calmer. Give yourself the opportunity to keep things simple. This will also help keep your stress level down.

Above all, take a deep breath and try to stay calm. When you work with young children, no one looks forward to those rainy days. Children are very receptive to the energy of others around them and if you can remain calm, use a softer voice and set up a soothing environment, you increase the likelihood of having a better rainy day. Remind yourself that rainy days can be crazy and that you'll do the best you can. If you can keep these things in mind, both you and your children may have an easier time on rainy days. ❖

Diversity

Growing up biracial/biethnic

by Paula Gerstenblatt, MSW

For child care providers working with biracial/biethnic children birth to 5 years old, understanding the child's perspective may be difficult since they are not able to articulate their experiences as older children can. I recently interviewed several biracial/biethnic teenagers to get a better understanding of what it is like to grow up biracial/biethnic. All of the teens interviewed addressed issues of identity and openly relayed their experiences and feelings. By listening to the thoughts and feelings of children at different developmental levels, we can better respond to the needs of biracial/biethnic children and families utilizing child care services. The following excerpts are not meant to represent the experiences of all biracial/biethnic children. It is important to remember that, although some issues are consistent, each family has different variables and circumstances.

***Melania**, age 17; mother is Jewish, father is Nicaraguan*
"When parents raise you in both cultures, being biracial is not a problem. As a person, I do not feel I really fit in any one place, so I can go anywhere I want and get away with it. I grew up around both traditions. They are harmonized inside of me and, in fact, that makes me special."

***Hannah**, age 17; mother is white, father is Japanese*
"People don't look at me and think I am Japanese, they think I am mixed with Latino. I sometimes regretted not having one cultural identity as some of my other friends have. My only negative feelings about being mixed are that I never really feel I belong. When people ask me what I am, I say 'Japanese and white.' I think there should be a category for biracial/biethnic people. I am not one or the other, and it feels as if you are selling yourself short not to include both."

***Jonathan**, age 14; mother is white, father is black*
"I don't think of myself as biracial. Even though I see myself as black, I feel very connected to being Jewish and to my mother's Jewish family. Most of my friends are black, but I have other friends too. People see me as black, but people who know me also know that I am very Jewish. I have traveled to Greece and France and have friends from different countries as well."

For more interviews, the book *"What Are You? Voices of Mixed-Race Young People,"* edited by Pearl Fuyo Gaskins and published by Henry Holt and Company, Inc., 1999, is an excellent resource. ❖

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Inclusion insights

Secrets to the system

by Pamm Shaw, MA, Disabilities Specialist

It always surprises me to realize that the more I think I know, the less I know. Just recently, I found that Community Care Licensing has a "mainstreaming policy." This policy allows child care programs to share classroom and playground space with special education programs as long as they stay within the licensed capacity. The children enrolled in the special education program do not have to be enrolled in the child care program to participate. Agencies must submit a plan to Licensing but do not need to request a waiver.

Other tips...

Get to know your licensing advocate. Their statewide network shares information about what is working across the state. The advocates are there for you. To find the advocate in your area, call (916) 229-4269 or your local Licensing office.

Get a copy of "California Special Education Programs, A Composite of Laws." Call CDE publications at (800) 995-4099 or (916) 445-1260 for your free copy. This resource includes state and federal laws for children with disabilities from birth through age 22.

Get training, or create your own. Work with your local community colleges to develop classes, programs and training opportunities for working with children with special needs. There are 20 plus colleges participating in a paraprofessional training project to develop certificate programs in early intervention/early childhood special education that links with the Child Development Permit Matrix. Call (916) 492-9999 for more information.

Keep track of what your local Children and Families Commission (Prop 10) is funding as well as what is happening at the state level. This is a very large, new infusion of money for early childhood programs. Some counties are funding specific services and supports for children with special needs and their families. The State Commission has approved funding for a study on the barriers to inclusive child care, infant mental health services, and health and family support consultants.

The state-funded child care subsidy programs have increased reimbursement rates for children with special needs who meet certain eligibility requirements. The funding is limited by the market rate for child care in a community and usually does not provide enough funds for additional staff or supports. If the family is in the CalWORKs Program, there may be mental health and family support funds available to assist children with special needs in child care. Check with your local CalWORKs coordinator for more information.

These are a few of the ways you can help the children and families in your care. Check out their Web site at **www.ccfc.ca.gov/**. ❖

Health and safety calendar

March

9-11: CAEYC 23rd Annual Public Policy Symposium and Annual Conference, Sacramento. (916) 442-4703.

22-24: California Child Development Administrative Association Conference, San Diego. (562) 427-8834 or (626) 854-3449.

23-24: Pilots to Policy 2000: Schools, Communities, and Government Working Together for California's Kids and Families, Los Angeles. (415) 616-3930.

24-26: Child Care is the Building Block of the Future 2000, Association for Family Child Care (formerly East Oakland Licensed Day Care Association), Napa (510) 658-2449.

April

6-8: The 18th Annual California School-Age Care and Recreation Training Conference: Building Memories, Balancing Experience, Pasadena. California School-Age Consortium, (415) 957-9775.

9-11: California Child, Youth & Family Coalition and the Western States Youth Service Annual Spring Conference—Beyond Isms: Embrace the Human Race explores how to achieve inclusiveness, Sacramento, (916) 340-0505.

9-15: Week of the Young Child. Materials available from NAEYC at (800) 424-2460.

28-29: The Color of Violence: Violence Against Women of Color, Santa Cruz. Contact Andrea Smith at the U.C. Santa Cruz Women of Color Research Center at (831) 460-1856.

May

May 31-June 1: Realizing the Promise of Diversity in the 21st Century, Sacramento. (916) 498-6960.

Creating a CalWORKs/child care partnership

by Betty Z. Bassoff, DSW

I have recently completed 14 trainings for all of San Diego County's CalWORKs front-line staff—a total of 900 participants. The trainings resulted from a redesign of the existing child care system to improve its "customer service" quality. I want to share what I have learned about our common interests and how we can work together more effectively.

First, it was clear from the outset that we knew very little about each other. The basics about how each field is organized, who pays for services, what services families receive, and what we expect from each other as well as our families needed to be spelled out. It's difficult to respect what you don't understand, and our systems seem like "foreign ground" to each other. We set the stage in the training for partnership foundations, shared goals, and the family as our focus.

Second, planning for child care placement must start early in the admission process for CalWORKs job placement, must include orientation to the range of child care options available and must encourage the choice of quality care. We are asking that this process start during pregnancy. Backup care should be included in this planning, as most of our clients will have very young children who will, predictably, be ill many times during the work period. CalWORKs staff need to know the conditions under which children may be excluded from licensed care and how this will affect their client's work experience. The critical importance of child care to parent participation in welfare-to-work activities became apparent in planning for the training.

Third, our CalWORKs partners need to have a list of all helpful resources for planning with their clients and a few key names to help when there is an unusual situation. Our list included our resource and referral agency, the city child care coordinators, the alternative payment programs, Head Starts, the 6-to-6 programs, our child care health consultant service at the YMCA Childcare Resource Service, and a payment hotline number. Others could be added.

Finally, we must develop our communication channels: When do we need to talk with each other, and, at the same time, how do we protect the confidentiality rights of the clients?

I found a ready willingness to create a partnership. We are both working toward the same end—to help each family achieve full independence and a better life. If you have other suggestions to offer, please contact me at (619) 594-4373. ❖

Do your part to prevent baby-bottle tooth decay

More than 10 percent of young children experience early childhood caries, also known as baby bottle tooth decay. Young children with untreated dental caries may develop poor eating habits and speech problems, and they are at increased risk for future dental caries.

Baby bottle tooth decay is caused by frequent and prolonged exposure of children's teeth to carbohydrates, particularly sugar in milk, fruit juice or infant formula. Bacteria in the mouth use these sugars as food and then produce acids that attack the teeth and cause decay.

The following steps will help to prevent children from getting baby bottle tooth decay:

- Never put a child to bed with a bottle containing sugary liquids, including milk. Use a pacifier or bottles filled with water for children who find sucking a comfort and have trouble falling asleep.
- Rubbing the child's stomach, offering the child a stuffed animal, or holding or rocking the child are good alternatives to a bottle at bedtime.
- Encourage the bottle-fed child to make the transition from bottle to small cup by the age of 12 months.
- Regularly clean gums and teeth, and remember that this is just as important for breastfed babies.
- Clean the child's teeth daily from the beginning.
- Ensure that the child receives a first dental visit by the age of 12 months.
- Help the child develop good eating habits early and choose sensible, nutritious snacks.

***Source**: National Center for Education in Maternal and Child Health*

Product watch

The U.S. Consumer Product Safety Commission (CPSC) recently launched **Operation S.O.S. (Safe Online Shopping)** to find more recalled, illegal and potentially hazardous consumer products being sold on the World Wide Web. CPSC investigators are now secretly monitoring the Internet for possibly dangerous and illegal consumer products. CPSC already has found dangerous products being sold online, including flammable children's sleepwear, prescription drugs without child-resistant packaging, children's jackets with drawstrings (a strangulation hazard), mini-hammocks without spreader bars, and more.

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Child care health consultation

(continued from page 1)

providers, as well as improved nutrition education services. Collaboration with the local Prop. 10/Children and Families Commission and Child Care Planning Council has resulted in a plan to improve health and child care services to young children.

Challenges for the future include working for greater access to affordable health and safety training, building stronger linkages within health services to deliver health promotion and prevention activities to child care programs, and developing improved user-friendly health consultation services. But mostly, it is our job to respond to needs expressed by the child care community now faced with an increasing demand for services, especially for infants, and a corresponding shortage of well-trained and well-paid staff. Since many of our youngest children spend more of their waking hours in child care than in their own home, attention to caregiver health and to the child care environment is critical. ❖

Mildly ill children

(continued from page 3)

- Should there be any change in the amount or type of fluids the child drinks?
- What type of medicine is she taking and will you need to give it?
- What observations should you be making?
- If treatments are needed, are you expected to give them? Who will teach you, and are there any other special instructions?

Make sure you have a way to reach the parent on that day. When you understand the child's special needs and have a way to meet them, you are caring for a mildly ill child.

On the days that you cannot provide care for the child, have a list of alternatives. Investigate your community's resources: Sick Child Care Programs, Home Health Agencies, nanny or babysitting services. Make contact and learn about their services and fees. Encourage your parents to arrange for back-up care at the time of enrollment. You can then truly say that you care for mildly ill children. ❖

Legislative update

by Marsha Sherman, CCHP Director

The new legislative year is just beginning, and the next issue of *Child Care Health Connections* will identify those bills which connect health, safety and child care. One bill, **AB561** (Romero), sponsored by the California Child Care Health Program, is still alive and well. The bill was introduced in the Assembly last year and was passed on to the Senate before the end of the 1999 session. It is now awaiting passage in the Appropriations Committee and goes on to the full Senate for approval.

The original bill creates The Child Care Health Linkages Project. This project establishes a trained Child Care Health Consultant in six counties and Family Health Coordinators in a selection of child care centers. The exceptionally good news is that the "Linkages" project has been approved for funding by the California Children and Families State Commission for implementation in an estimated 20 counties. If the legislation passes, we could fund many more counties with matching funds.

Please let the Governor and your senators know that you support this legislation. Even if you wrote letters or made phone calls last year, *we need new letters and phone calls*. Call the Governor at (916) 443-7511 and send letters to Hon. Gray Davis, Governor, State Capitol, Sacramento, CA 95814. ❖

Product watch

(continued from page 10)

50 model/styles of Kolcraft infant car seat/carriers manufactured from January 1993 through June 1999 have been recalled for repairs. When used as an infant carrier, the handle can unexpectedly move from the intended carrying position, causing the seat to suddenly rotate and the infant can fall to the ground. Call Kolcraft toll-free at (877) 776-2609 to obtain a free repair kit. Consumers can continue to use the product as a car seat or in combination with the stroller, but until the carrier has been repaired, do not to carry the seat by its handle.

Kelty K.I.D.S. backpack child carriers, also sold under L.L. Bean's "L.L. KIDS" label and distributed nationwide from March 1999 to December 1999 have been recalled for repairs. The seat height adjustment strap on these carriers can slip out of the buckle, possibly causing a child to slide downward and fall out. Consumers should immediately stop using these backpack carriers and contact Kelty at (800) 423-2320 for a free repair kit. For more information, visit Kelty's Web site at **www.kelty.com**.

Resources

Products and resources described in this section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Bringing Education to After-School Hours by the Department of Education. Free; call (877) 4-Ed-PRESS, available online at www.ed.gov/pubs/After_School_Programs

Employer Child Care Resources: A Basic Guide for Developing Effective Child Care Programs and Policies is a basic guide to developing workplace child care. Covers need assessments such as school-age programs, day care networks and nonstandard care. Free; Women's Bureau National Resource and Information Center, (800) 827-5335, **www.dol.gov/dol/wb/**

State Children's Health Insurance Program: Here's a new, toll-free number to help families find out if their children are eligible for free health insurance under this program: (877) KIDS-NOW (877/543-7669)

Online Resources

Access to Child Care for Low-Income Working Families discusses the unmet needs of families eligible for federal child care. Visit **www.nccic.org**

Kinder Art is an extensive Web site full of art and crafts ideas for early childhood and school-age care. Also offers art lessons, multiple links. Visit **www.kinderart.com**

New Spanish Health & Safety Notes available from CCHP

Recomendaciones Generales para Limpiar, Sanitizar y Desinfectar el Local de Cuidado Infantil (General Recommendations for Cleaning, Sanitizing and Disinfecting in the Child Care Setting)

La Exposición a Enfermedades Contagiosas (Exposure to Communicable Disease)

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La Línea de la Salud (Child Care Healthline)

¡Ahora la Línea de Salud se responde en Español! La Línea de la Salud para Proveedores de Cuidado Infantil tiene una enfermera bilingüe quién puede ofrecerles consejos sobre la salud y la seguridad de los niños bajo su cuidado.

La línea esta abierta de las 8 de la mañana hasta las 4 de la tarde, del lunes a jueves. Por favor, llame al (800) 333-3212. Se pueden dejar mensajes a cualquier hora. Estámos áqui para servirles.

A bilingual public health nurse is now available to answer calls in Spanish as well as English! The Healthline operates between the hours of 8 a.m. and 4 p.m., Monday through Thursday. Messages may be left at any time. We look forward to hearing from you. Call (800) 333-3212. ❖

What is a "medical home?"

by Betty Z. Bassoff, DSW

In the last issue we reported the good news that the "Linkages" project, originally submitted to the legislature as AB561 (Romero), was approved for funding by the California Children & Families (Prop 10) Commission for implementation in up to 20 counties. An important objective of that project is to assist child care families in obtaining needed resources in the community.

A most important resource for every child in our care is access to basic and specialized health care where and when needed. The American Academy of Pediatrics (AAP) calls this service a "medical home," and defines it as an approach to health care where "children and their families receive the care that they need from a pediatrician or physician whom they trust."

The AAP believes that the ideal medical home is a primary care physician working in partnership with a child's parents. This partnership would address the needs of the whole child, making connections through referrals to needed resources. We want to add the child care provider to that twosome, making a great team of three.

So what does this mean to us? The Health Coordinator role, which will be created through the Linkages project, will serve to help families find a medical home for their children in a society where many working families have no medical coverage and are forced to use the emergency room as their only source of health care. The health of the children in our care is our first consideration. Helping them obtain whatever care they need, whether it is to prevent illness or to meet special needs, is the goal for CCHP. ❖

Highlights of what's inside:

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH

QUESTION:

Are children required by law to wear bicycle helmets when riding a bicycle?

ANSWER:

Yes! Children should wear a helmet every time they ride, and this practice should begin with tricycles. Helmets are also needed when children use skateboards, roller skates or in-line skates. California law says that all children who ride bicycles must wear a helmet (Safe Bicyclist Protection Act, Vehicle Code Section 21212).

Nothing is more enjoyable than a leisurely ride on a bicycle on a warm summer afternoon, away from traffic congestion and the demands of our busy lifestyles. Bicycle riding can be a fun and exciting form of exercise, transportation and a family activity. But, like any activity that involves speed and sharing the road or paths with others, safety and proper awareness must always be in our minds.

Any helmet that has been involved in an accident must be replaced with a new one, even when you see no sign of physical damage.

One of the most important ways to protect children and adults when riding bicycles or tricycles is by wearing bicycle helmets. Almost 80 percent of all bicycle deaths are due to brain injury. Studies show that bicycle helmets reduce the risk of head injury by 85 percent and of brain injury by 88 percent. Wearing a helmet while riding a bicycle protects riders from brain injury should they fall or be hit by a car.

Bicycle helmets can be purchased inexpensively in several places including stores that sell bicycles, school PTA programs, discount stores, supermarkets and some police departments. Any helmet that has been involved in an accident must be replaced with a new one, even when you see no sign of physical damage. The old helmet could be unsafe and may have lost the ability to absorb the impact of another crash.

Here are some tips to help make bicycle riding safe for you and your children:

Protect your head: Wear a helmet.

See and be seen: Wear clothes that make you more visible. Clothing should be light in color and close fitting to avoid being caught in the bicycle's moving parts.

Go with the flow of traffic: You must obey the rules of the road.

Look both ways: Be aware of traffic around you.

(continued on page 11)

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The infant/toddler's world

Summers are full of fun and learning for babies and toddlers

by Cheryl Oku
Infant Toddler Specialist

When the weather turns warm, what could be more natural than spending time outdoors with babies and toddlers? The fresh air and open space invite children to use their senses and their whole bodies—their hands and arms, their feet and legs, their mouths. While they are busy playing and exploring, they are also learning rich sensory lessons. An infant can listen to the sounds of nearby cars or walkers, watch shadows, clouds or leaves moving in the wind, feel a warm or cool breeze on his face. A mobile baby could crawl over a soft, cool, grassy area onto a sunny, hard, wooden deck or gravelly walkway. A toddler can actively climb and jump, pour cool streams of water into sand, or dig in a small garden.

The young child who has these outdoor experiences is learning how his body works, is strengthening his muscles and developing coordination. When he picks up small rocks or twigs or tears a leaf, he is using small motor muscles. When he crawls, climbs, walks, runs, or kicks a ball, he is developing large motor skills.

As they run and chase, toddlers are learning about trust and their ability to find their friends and favorite adults. When they are free to choose to dig, climb, or ride wheel toys, they are learning about their autonomy. Toddlers love to use pretend play outdoors—taking babies for a walk, going to work, driving a fire engine—and they are making sense of the world. They are learning about the world around them when they do real work such as building, raking or gardening.

Here are some points to remember to keep babies and toddlers safe and healthy while they explore outdoors.

Babies explore with their mouths. Be sure the baby's area is free from objects that are sharp or small enough to present a choking hazard. Check for poisonous plants in your outdoor area.

Toddlers and twos will touch, dump, climb and jump. All equipment needs to match the age, size and physical abilities of the children. Climbing equipment must be placed over sand, gravel, wood chips or other cushioned material—never over concrete or other hard surfaces. Sandboxes should be raked often and covered at night. The play area must be adequately fenced so children can explore freely.

Protect them from the sun. To protect children from excessive sun exposure, encourage them to play outdoors early in the day and later in the afternoon. Keep infants in a shaded area out of direct sunlight and provide easily accessible shade for toddler play. Ask parents to bring a hat or other lightweight and breathable protective clothing. Apply sunscreen to mobile children to prevent sunburn (with parents' written permission).

Encourage children to drink plenty of water and remember to keep yourself well hydrated, too. ❖

Infant/toddler articles and resource development is funded by the Infant/Toddler Capacity-Building Fund from the Department of Education, Child Development Division.

How to help those whistling and wheezing school-age children

by Gail Gonzalez, RN

Wheezing, coughing, sneezing, tight chest, anxiousness, tiredness, rapid or difficult breathing, flaring nostrils, bluish lips or nails—one or all of these symptoms could mean you have a child in trouble with asthma. If you have ever experienced this, you know how frightening it can be for you and the child. Asthma is a condition that makes it difficult to breathe. It is not curable, but it is controllable, and often episodes like this can be avoided.

You can help a family and their child gain and maintain control of asthma. A school-aged child has probably had some experience with acute episodes and may know a lot about his disease, and you need to know, too. Medication is an important part of control. The child will probably take one medication on a regular basis to avoid attacks and another medication to open airways when symptoms start.

A child of 5 years or more can recognize his "triggers," the events that set off his asthma symptoms. Usual triggers are dust, pollen, molds, feathers, animal dander, smoke, change in atmospheric pressure, smells, fumes, infection, allergies or exercise.

What you can do, as the child care provider, is make sure you understand and document his/her triggers and symptoms. Know the child's medications and how and when he takes them. Agree with the parent on an Asthma Action Plan in the event symptoms start while he is in your care. Be sure to maintain an up-to-date list of emergency numbers for the child. School-age children are capable of understanding cause, effect and prevention. Developing a contract with the child allows

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Parents know best, don't they?

by Lyn Dailey, PHN

Providers acknowledge that parents are the best source of information about their child's needs, desires and development. They have an understanding of what works and what doesn't work, and how their child responds in particular situations. Providers also know that parents can be under heavy pressure and time constraints and sometimes don't want to place more demands on them. What does this mean when it comes to caring for a child with a special health or developmental need such as life-threatening allergies?

Is it really necessary to involve a child's medical provider if the parent can train the child care provider on how to use a special piece of equipment? A recent study (Pediatrics, Vol. 105 No. 2 February 2000) indicates the answer is "yes." Parents of children with severe food allergies were questioned about the use of self-injectable epinephrine and demonstrated the use of the prescribed device (such as EpiPen-Jr or EpiE-Z Pen-Jr.) which they were already using. The findings showed that only 71 percent of the 101 families had the device with them at the time of the survey (although 86 percent said they carried it at all times). 10 percent of those carrying the medication had a device that was past the expiration date, and only 32 percent of the parents and pediatricians were able to correctly demonstrate the use of the devices.

Requiring parents and guardians to bring you a current prescription and instructions for the use of medications and equipment is not just a burdensome trip back to the pediatrician. It is an opportunity for the parent to be properly trained or retrained on the procedure themselves. Many of the pediatricians in this study assumed that the pharmacist who dispensed the device would train the parent, and many of the parents never received written instructions. This could also apply to children and parents using nebulizers for asthma and glucose monitors for diabetes. Your role in assuring that you get the information and training you need will help the parents get the same thing—and the child benefits.

Is it really necessary to involve a child's medical provider if the parent can train the child care provider on how to use a special piece of equipment? A recent study indicates the answer is "yes."

This is the type of teamwork that is required between parents, medical providers and child care providers to safely meet the needs of children. The product of this teamwork is a Special Care Plan that is updated at least annually or whenever the child's needs change.

Call the Healthline if you need sample forms to help you get started or if you want to discuss caring for a child with a special need. ❖

Product Watch

Prince Lionheart Baby Wipe Warmers with style number 0224 and date codes between 9803 and 9901 are being recalled by Advanced Thermo Control (ATC). Possible cracks in the interior tub of these wipe warmers can allow water to contact the electrical components, which can result in consumers receiving an electrical shock. Consumers should immediately unplug the warmers, remove the wipes and check to see if the interior tub is cracked. If cracks are found, stop using the warmer immediately, and call ATC at (888) 843-8718 for a free replacement unit.

Certain baby mattresses and mattress pads are being marketed that encourage the potentially deadly practice of placing babies to sleep on their stomachs and claim that the products reduce the risk of Sudden Infant Death Syndrome (SIDS), warns the U.S. Consumer Product Safety Commission (CPSC). Despite these marketing claims, CPSC is not aware of any evidence that proves that babies can safely be placed to sleep on their stomachs on these products or that using the products will reduce the risk of SIDS. Due to CPSC efforts, these firms have stopped manufacturing and distributing the products. ***Parents and caregivers should never put babies to sleep on their stomachs, whether on these products or any others.*** According to CPSC, the risk of SIDS is significantly reduced by placing babies to sleep on their backs in a crib that meets current safety standards and has a firm, tight-fitting mattress and no soft bedding. ❖

Children and sexuality

by Diane Hinds

Reprinted from the Citrus College, Child Development Center's Newsletter, February 2000.

Young children are learning, growing and developing at an amazing rate in all areas. Parents and teachers are delighted in their growth with few exceptions. Sexual awareness seems to be one of the exceptions. In spite of our cognitive awareness of the fact that children between the ages of 2 and 6 will become aware of genital differences between the sexes, develop curiosity about how babies are made, and explore their own and their friends' bodies, many of us become acutely uncomfortable when supporting children's growth in these areas.

Laying the foundation

During the early years, we are laying the foundation for future development. Parents need to clarify in their own minds what it is they want for their child in the area of sexuality. If these values are clearly in mind, it is somewhat easier to respond to specific incidents in a way that promotes growth in those values. Values to consider might include sexual enjoyment, freedom to express oneself sexually, health issues, responsibility for sexual behavior, respect for one's body, respect for other people's bodies, exploitation of sex and procreation. This is a partial list, and individual families will have a variety of additional issues to consider. In addition to the value system, adults must consider the age of the child. Children will exhibit certain behavior and be able to assimilate information based on their age. For example, the child discovers his genitals in much the same way he discovers the rest of his body, with a great deal of touching. This will occur between one and two years of age and, because the touching is pleasurable, will likely continue or expand into masturbation. Touching of the genitals may also become a response to nervousness or boredom.

In most cases, touching or self-exploration in the first 2 or 3 years should be considered part of the process of learning about the body. The older child should be responded to in a way consistent with the family's values. Developmentally-appropriate responses range from ignoring the behavior to setting limits as to when and where the behavior is allowed, i.e., "I know that feels good, but playing with your penis is private. You need to do that in your room."

Children's natural curiosity will next lead to exploration of other children's bodies. This "sex play" may be exploitive with an older child of 4 or 5 undressing and handling the genitals of a younger child or it may be mutual with children taking turns looking and touching. Either way, many adults are offended or upset when confronted with this behavior. It is important to remember that this behavior is normal and that the situation can be used to teach your values.

Redirecting a child's focus

Redirection and attempting to address the child's natural curiosity may be the most appropriate response. The adult may also want to establish the rules for appropriate behavior, i.e., "Johnny, I can't let you touch the private parts of Susan's body. I have a book you can look at to see what a girl's body looks like. Let's go get the book and look at it together."

Children may attempt to insert objects in genital openings. This behavior can be labeled as unsafe and likened to putting objects in the nose or ears, i.e., "I can't let you put that in your vagina. That could hurt your body just like it could hurt your ear or nose to put something into it."

Children may imitate what they have seen at home

Children exploring on their own will not usually link kissing and hugging with body exploration, however if they have observed these events in combination through television, observing their parents, looking at pornographic literature or by observing other children, then they may simulate intercourse or other sexual behavior. Immediate redirection is appropriate in these circumstances. Parents observing this behavior or receiving reports of this type of behavior from their preschool, should try to determine where their child was exposed to this material and see that the child is protected from additional exposure to inappropriate, sexually-oriented material.

Young children are not ready to deal with sexually explicit material and must be protected from it! They are often exposed to inappropriate, sexually-oriented material at the movies or even at home on television. They may also have

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HEALTH & SAFETY NOTES

California Child Care Health Program

EAR INFECTIONS (OTITIS MEDIA) AND HEARING LOSS IN YOUNG CHILDREN

What Is Otitis Media? Ear infection, also called otitis media or inflammation of the middle ear, is an infection of the part of the ear behind the eardrum. Next to the common cold, otitis media is the most common illness diagnosed during childhood. It's also one of the most common reasons for the prescription of antibiotics and other medications to children.

Who Gets It and How? Middle ear infections are common in children between the ages of one month and six years, and most common under age three. Ear infections can run in families, and boys are more affected than girls. Some children develop ear infections a few days after a cold starts. Some children have one infection after another, whereas others never have any. Conditions that increase a child's risk of ear infections are frequent colds, allergic runny noses, bottle propping, exposure to smoke and attendance in group settings such as child care.

What Are the Signs and Symptoms? Symptoms result from swelling of the middle ear. The child may cry persistently, tug at the ear, have a fever, have trouble sleeping, be irritable and unable to hear well. When infection occurs, pus develops, pushes on the eardrum, and causes pain and often fever. Sometimes the pressure is so great that the eardrum bursts and the pus drains out into the ear canal. Although this yellow-white discharge may frighten parents, the child feels better and the hole in the eardrum will heal over. Sometimes the child may have diarrhea, nausea and vomiting.

What Are the Complications? Most of the time ear infections clear up without causing any lasting problems. However, if not treated, otitis media can cause problems such as hearing loss, infection of the inner ear, and even meningitis. Fluid may remain in an ear as long as six months after an infection is gone.

When Should a Child Be Excluded? Since ear infections themselves are not contagious, there is no reason to exclude the child from your facility unless he or she has a high fever, cannot participate in activities because of pain, or needs more care than you can give without compromising the care given to other children.

How Can You Limit the Spread?

Prevent the spread of colds and other upper respiratory infections which may lead to otitis media:

- Practice good handwashing.
- Teach children to cough into their elbow and away from people.
- Wipe noses with clean tissues, dispose of them properly and wash your hands.
- Don't share food, bottles, toothbrushes and toys that can be put in the mouth.
- Play outdoors often, and let fresh air into your program daily.

Take care of children who have frequent ear infections:

- Never use cotton swabs and never put anything smaller than your finger into a child's ear. Do not allow the child to do so either.
- Do not feed or bottle-feed infants lying on their backs. Never prop bottles while feeding.
- Be especially alert for any sign of hearing or speech problems that may show up. Refer the child to the family's health care provider or other community resources.
- Be sure that prescribed antibiotics are taken for the full amount of time to avoid resistant infections.

Care for children who have ear tubes:

- An ear tube creates a hole in the eardrum so fluid and pus may drain out. It usually stays in for three to six months.
- Since pus can drain out, water from the outside world (which has germs in it) can also run into the middle ear easily. Therefore, you must be very careful that children with tubes do not get water in their ears. This usually means no swimming unless there are special earplugs and permission from the health care provider. Watch for any sign of hearing or speech problems.

Take care of children who have hearing loss:

Frequent, undetected or untreated ear infections can lead to permanent hearing loss, delayed speech and language development, social and emotional problems, and academic failure.

California Child Care Health Program • 1322 Webster St., Suite 402 • Oakland, CA 94612-3218
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212
www.childcarehealth.org

The earlier hearing loss is identified, the sooner effective treatment can begin. Some babies are born with hearing problems. Other children are born with normal hearing and begin to have problems as they grow older. Hearing problems can be temporary or permanent. Hearing loss can be caused by ear infections, injuries or diseases.

If you think your child or a child in your care has a hearing problem, have the parent talk with their primary health care provider.

The following checklist identifies some of the more common risk factors associated with hearing loss:

- ✓ Family members, including brothers and sisters have a hearing problem or history of ear infections.
- ✓ The child's mother had medical problems in pregnancy or delivery (including serious illness or injury, drugs or medications).
- ✓ The baby was born early (premature) and/or had physical problems at birth.
- ✓ The child rubs or pulls on ear(s) often.
- ✓ The child has frequent ear infections, colds or allergies.
- ✓ The child had scarlet fever or meningitis.

Baby's Hearing Checklist

Use this checklist to share with parents or health providers to determine if there is a hearing loss.

Yes No Birth to 3 months

- ❑ ❑ Reacts to loud sounds
- ❑ ❑ Is soothed by your voice
- ❑ ❑ Turns head to you when you speak
- ❑ ❑ Is awakened by loud voices and sounds
- ❑ ❑ Seems to know your voice and quiets down if crying
- ❑ ❑ Smiles when spoken to

3 to 6 months

- ❑ ❑ Looks up or turns toward a new sound
- ❑ ❑ Imitates his/her own voice
- ❑ ❑ Responds to "no" and change in tone of voice
- ❑ ❑ Enjoys toys that make sounds
- ❑ ❑ Begins to repeat sounds (like ooh & ba-ba)
- ❑ ❑ Becomes scared by a loud voice

6 to 10 months

- ❑ ❑ Responds to own name, telephone ring, someone's voice, even when not loud
- ❑ ❑ Knows words for common things (cup, shoe) and sayings ("bye-bye")
- ❑ ❑ Makes babbling sounds, even when alone
- ❑ ❑ Starts to respond to requests such as "Come here."
- ❑ ❑ Looks at things or pictures when someone talks about them

Yes No 10 to 15 months

- ❑ ❑ Plays with own voice, enjoying the sound and feel of it
- ❑ ❑ Points to or looks at familiar objects or people when asked to do so
- ❑ ❑ Imitates simple words and sounds; may use a few single words meaningfully
- ❑ ❑ Enjoys games like peek-a-boo and pat-a-cake

15 to 18 months

- ❑ ❑ Follows simple directions, such as "give me the ball"
- ❑ ❑ Often knows 10 to 20 words
- ❑ ❑ Uses words he/she has learned
- ❑ ❑ Uses 2-3 word sentences to talk about and ask for things

18 to 24 months

- ❑ ❑ Enjoys being read to
- ❑ ❑ Understands simple "yes-no" questions (Are you hungry?)
- ❑ ❑ Understands simple phrases ("in the cup," "on the table")
- ❑ ❑ Points to pictures when asked

24 to 36 months

- ❑ ❑ Understands "not now" and "no more"
- ❑ ❑ Chooses things by size (big, little)
- ❑ ❑ Follows simple directions such as "Get your shoes," and "Drink your milk."
- ❑ ❑ Understands action words (run, jump)

***By Rahman Zamani & Pamm Shaw** (March 28, 2000)*

References:

American Academy of Audiology, "Hearing Loss in Neonates and Infants: Hearing screening." 8201 Greensboro Drive #300, McLean, VA 22102, 800-AAA-2336.

The National Institute on Deafness and Other Communication Disorders, "Silence Isn't Always Golden." NIDCD Information Clearinghouse, 1 Communication Ave., Bethesda, MD 20892-3456, 800-241-1044

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Behavioral health

Early childhood mental health series begins

by Jennifer Smith, MA

Because it is such an important topic, you will see a series of articles on early childhood mental health in the following months. There is so much to know about the early social/emotional development of young children and its powerful impact throughout their lives. It is my hope that this will encourage you to learn more about how to promote healthy social/emotional development in the lives of the young children for whom you care.

All of us are born into this world needing the care of another. The human species is different than many other living creatures, because we depend upon another person caring for us in order to survive—literally. Babies are born equipped with only a few ways they can let us know they need something from us which they can't do for themselves. How do they usually tell us? They cry. Then they may smile or coo and goo at us to let us know we have met their needs. They give use a cue; we do something to respond. Through these interactions babies are learning that the people in their world can meet their needs, that the world is a safe place to be and that they can trust they will be cared for.

As a baby gets older, s/he develops more abilities to communicate needs. As coordination of the body develops, the child can begin to do more things to let needs be known, such as moving toward the desired object, kicking or wiggling when uncomfortable, and then pointing and beginning to use simple language skills to communicate. This growing toddler is also developing more ways to let you know that you've read cues correctly. S/he may smile at you, hug you, soothe and calm to your touch, or laugh. All of these signals let you know that the child is taking pleasure in you and trusting in your ability to respond to his/her needs.

As you may have experienced, preschool-aged children have a broad variety of ways they can communicate their needs. Young children this age can not only walk toward what they want and get it, they can run! They can also use more sophisticated language to express themselves. They can tell you they are hungry and that they want a hot dog, not pizza. Because these children are older, they have developed even more ways to let you know how your relationships with them are working. The key towards understanding children is their behavior, both verbal and nonverbal.

Early childhood mental health changes and develops over time, as does the child. It is a concept that emphasizes the interaction and exchange between a child and the significant caregiver(s) in his/her life, the patterns of relating that develop and what the child is learning through these interactions. You can think of a dance between two partners: Children give us cues, we respond, and they react to our responses. It is through these patterns of interaction that a child learns to develop trust in the world. Children's sense of well-being originates and develops from their experiences in their relationships with others in the world.

In the next issue, I will address the importance of these relationships and exactly how they impact the overall development of young children. ❖

May is National Mental Health Month. Please see the Resources section on page 12 for more information.

Diversity

Integrating materials and activities on biracial/ biethnic children

by Paula Gerstenblatt, MSW

QUESTION:

As a child care provider, what will I have to do differently for biracial biethnic children?

ANSWER:

The first step is to clarify your own values and assumptions about working with biracial/biethnic children and their families. Familiarize yourself with the unique issues facing biracial/biethnic children and validate each child's experience. If you are doing activities with a family theme, be sure to mention different kinds of families, including biracial/biethnic children who are transracially adopted. Activities such as photo collages, family trees and family portraits are ways for children to proudly illustrate their families and can be a natural springboard for discussion. Different textures of hair, varying hues of skin color and languages other than English are some of the things that make us different. Making mention of the diversity in each family and how beautiful it is validates each child's experience.

When celebrating cultural practices and holidays, recognize that some children participate in more than one celebration or practice. This can alleviate the pressure a child may feel to choose one identity over the other. Having a selection of books, posters, varying hues of crayons and paints allows children to accurately identify themselves and their family. Ask children to

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BEST COPY AVAILABLE

Inclusion insights

Everyone counts!

by Pamm Shaw and Sandra Zehaye

Our title this month is taken from the US Census. "Everyone Counts!" The Map to Inclusive Child Care Project needs your help to make sure they do. We are getting ready to complete a report on the barriers to child care for children with disabilities and other special needs for the California Department of Education, Child Development Division (CDD). We are also coordinating this effort with WestEd Center for Prevention and Early Intervention to expand the report to an in-depth, research-based analysis of the barriers to inclusive child care. We will be facilitating focus groups as part of collecting information, disseminating surveys (see insert in this newsletter), conducting interviews with families of children with disabilities, preparing case studies and reviewing data from all of the state departments which collect information on child care and children with special needs.

Our goal for the CDD report is to clearly describe the confusion and difficulty for families, the fears of providers, the rifts in the multiple systems serving children with special needs and their families, as well as tell success stories of what is working, most effective practices and training opportunities. The report will include recommendations to help policy makers begin the process of closing the gaps in the existing system, as well as assist in creating an infrastructure to support and care for children with disabilities and other special needs, their families and the personnel who serve them.

You can help us by completing the survey in this newsletter and returning it to us. Thank you in advance! Any questions, comments and/or success stories? Call us at (510) 839-1243, fax to (510) 839-0339 or e-mail to calif map *a* aol com. We will publish a summary of the results in an upcoming issue of this newsletter.

Meet two new CCHP staff members

As Healthline callers may note, there is a new Special Needs voice on the line: ***Sandra Zehaye*** began working for the Child Care Health Program in January. She holds a Master's degree in Early Childhood/Special Education and an Integrated Service Specialist (ISS) certificate from San Francisco State University. Sandra has worked 11 years in the field of early intervention, as well as with Head Start and resource and referral, and has had her own child care center.

Chris Carducci joins our team as a student intern. Chris is working on her ISS certificate from San Francisco State and is finishing her Master's in Early Childhood/Special Education. Chris also teaches preschool at Foothill College in Los Altos Hills, CA. Sandra and Chris are both working on the Map to Inclusive Child Care Project. We are thrilled to have both of these talented people here. ❖

Oh, my aching back...and other caregiver health challenges

by Judy Calder, RN, Alameda County Health Services, Child Care Health Consultant

Caregivers of young children rarely think of their own health because they are usually so focused on caring for others. But child care providers should know what health and safety risks they face on the job, ways to reduce those risks, and the laws designed to protect them from illness and injury on the job.

The major risks are from exposure to infectious diseases, some of them considered serious enough to be occupational risks. In addition, daily routines of lifting and carrying children and moving heavy objects may cause muscle strains and sprains which, research cites, are the most common occupational injuries. Exposure to some chemicals, especially bleach and other cleaning products, may cause reactions. And, lastly, the stress and noise of caring for young children may be considered a health risk.

Promoting good health begins with a good employee health assessment by a health professional. The exam should include a health history, physical exam, TB screening, vision and hearing screening, a review of immunization status and history of childhood disease, and evaluation of functions related to job performance.

This exam should be followed by risk-reduction education by the child care employer during the period of employee orientation. Orientation is part of an injury and illness prevention plan required by law (OSHA). It must include ways to reduce exposure to illness and address handwashing, environmental sanitation and universal precautions to prevent infections spread through blood. The Hepatitis B immunization must be offered if a new worker is not immune, or for any worker who has a potential "blood exposure" and is not

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Children and sexuality

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inappropriate experiences when playing with other children or visiting other homes. Remember, you are teaching your child a value system and it is acquired during daily living and activities. Be sure that you are providing experiences to reinforce your values and avoiding experiences that detract from your values.

Sexuality in the school environment

In the school situation, children with a variety of experiences, from homes with a variety of different value systems and a variety of parenting techniques are combined. In our Center we serve a broad spectrum—from families that are uncomfortable about our open bathrooms to families that allow unlimited sexual exploration at home.

We have selected a value system to be used at school that is based on research and recommended for all young children. Our objectives for responding to children's sexual behavior are:

- To promote the child's self-esteem
- To promote an acceptance of one's own body
- To promote respect for the body privacy of others
- To promote appropriate language to discuss one's body

Generally, we respond to sexual behavior in a matter-of-fact way. We are comfortable in the knowledge that sexual play is normal and healthy behavior. We are teaching the social skills to handle sexual behavior in the early years. We ignore most self-exploration and redirect most shared sexual play. Our message to children is that underwear needs to stay on at school. ❖

Diversity

(continued from page 8)

describe the different kinds of families they see and are part of. Maintain a positive tone during discussions, emphasizing commonalities as well as differences. As human beings, we are members of families, share common interests, live in communities, go to sleep when we are tired and eat when we are hungry. We are different and alike at the same time!

For some biracial/biethnic families, there are sensitive issues connected to race, ethnicity and family. Issues such as being cut off from extended family may surface during a discussion or a parent-teacher conference, or perhaps be triggered by an activity with a family theme. It is important to understand how the family is impacted, and how this may affect a child in interactions with peers. Some points to remember are listed below:

- It is important not to ignore comments about race or ethnicity, or leave questions unanswered. Respond to questions and comments honestly and age appropriately.
- Acquaint yourself with the ages and stages of racial/ethnic identity development.
- Involve parents—they are the best source of information on their children.
- Stay active in your search for activities and materials. Network with other providers on ways to be inclusive of biracial/biethnic children. The key to integrating activities and materials is flexibility, creativity and respect.

For additional information, please call me at the Child Care Health Program, (510) 281-7914. ❖

Aching back

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immune. Instructions on lifting children, moving heavy objects and other methods to reduce muscle strain must be provided if these functions are required by the job.

Information on safe handling of chemicals such as bleach must be provided and Material Safety Data Sheets (MSDS) must be available near the point of use. These sheets are available by calling the "800" number listed on the label of most products. Additionally, all employees must know where to report unsafe conditions and how to report a work-related injury or illness. Large programs should have a safety committee that meets quarterly to review injury claims and determine training and corrective actions to reduce injury.

There are many resources available through the local Occupational Safety and Health Administration office. Find your local office by looking under the "Local Government" pages in front of the White Pages in your phone book. Cal-OSHA can provide employers with a poster on the mandated requirements. The California Chamber of Commerce (800/331-8877) has compiled all the information for employees on an easy-to-read poster for a cost of $15.

Another great resource is the CCHP web site at **www.childcarehealth.org** under the Provider Health menu. There you will find back care posters, recommendations for pregnant workers and much more. Don't forget that some CCHP Health Notes, such as Universal Precautions, Staff Exclusion Guidelines, Cleaning Guidelines, will also help in your health promotion plan. ❖

Bilingual public health nurse joins Healthline staff

Charis Subil is the newest health consultant for the Child Care Healthline. She has been a Registered Nurse for more than 24 years and has spent the last 15 years working as a Public Health Nurse for the Santa Clara County Health Department. She has extensive experience working with Spanish-speaking clients in the areas of Maternal and Child Health. She has also developed and taught Spanish parenting and childbirth classes for various San Francisco Bay Area hospitals.

As a bilingual Health Consultant, Charis is now available to provide consultations in Spanish. The Healthline is now a more accessible resource to Spanish-speaking child care providers. Charis can be reached at the Child Care Healthline's toll-free number, (800) 333-3212, Monday through Thursday, from 8 a.m. to 4 p.m. ❖

Ask the nurse

(continued from page 2)

Stay alert. Watch out for obstacles in your path.

Use designated bike routes. Avoid busy streets and use bike lanes where available.

Keep your bicycle in good repair. Make sure it is adjusted properly.

Check brakes before riding. Use the brakes to control your speed, and make sure tires are properly inflated.

Bicycle riding resources currently available include the Bicycle-Pedestrian Clearinghouse, (800) 760-NBPC (6272). National Highway Traffic Safety Administration, Traffic Safety Hotline (800) 424-9393, Bicycle Helmet Safety Institute; **www.bhsi.org** or the Healthline (800) 333-3212. ❖

Whistling and wheezing

(continued from page 3)

him to participate in his care and helps him take responsibility for making some decisions.

Some specific things you can do in the child care facility to help avoid asthma attacks are: clean daily with a moist cloth rather than a dry one to reduce dust; prohibit smoking, fumes and strong scents in your program; minimize mold and mildew; avoid having furry and feathered pets near the asthmatic child; eliminate pests, especially cockroaches, with a safe control method; observe carefully for symptoms when it is hot and dry and the children are playing hard; and keep in touch with your air quality management authority which advises when the air is unsafe in your locale.

To learn more about caring for a child with asthma, call the Healthline at (800) 333-3212. Also, contact your local American Lung Association chapter for resource materials. A child with asthma deserves the chance to experience *all* that you and your program can provide. ❖

Legislative update

by Marsha Sherman, CCHP Executive Director

The **Child Care Health Linkages** bill (**AB561**-Romero) continues in the Appropriations Committee of the Senate. It has passed and been approved by the Assembly. We are working hard to allocate funds to this bill in the hopes of matching all or part of the state Prop 10 funding for Child Care Health Linkages. The goal is to support Linkages projects in as many counties as possible.

For updated information on the bill, check the legislation website at **www.sen.ca.gov**.

There are many child care bills still developing. In our next newsletter, we will select a few which clearly impact the health and safety of children in child care. ❖

Health and safety calendar

May

1-31: Toddler Immunization Month. Call your health department for information and materials.

1: Worthy Wage Day. Ensure quality child care for children with adequate wages for child care workers. For information, contact the Center for the Early Childhood Workforce, (800) UR-Worthy.

23-25: Housing California 2000 Conference, Sacramento, (916) 447-1867. **www.housingca.com**.

31-June 1: Realizing the Promise of Diversity in the 21st Century. Sponsored by the California Department of Health Services, Maternal and Child Health Branch, San Diego Center for Collaborative Planning, 1401-21st Street, 4th Floor, Sacramento, CA, (916) 498-6960.

June

1: Stand for Children Day. Advocate on behalf of children and families through community action. For information, contact Stand for Children, (800) 663-4032.

23-24: Infant Toddler Consortium Conference, Berkeley, (510) 658-9189.

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

After School Catalog. Resources for Before and After School Care and Summer Programs for ages 5-14. Free by calling (800) 410-8780 or visit **www.schoolagenotes.com**

Child Health USA: The 10th Annual Report from the Maternal & Child Health Bureau has data on the health and health coverage of infants and children. Free by calling (800) 434-4MCH, or visit **www.mchirc.net/CH-USA.htm**

Child Support and Low-Income Families: Perceptions, Practices, and Policy explores how the child support system fails many low-income families and recommends system reforms reflecting low-income social and economic realities. Free by calling (415) 291-4400 or visit **www.ppic.org**

Online Resources

California Report Card '99 and California County Data Book '99 examine data on family economics, health, education and safety. They include recommendations for child care, health insurance and Prop 10 planning. **www.childrennow.org**

Ten Critical Threats to Children, from a coalition of organizations including the National School Boards Association, describes threats to children including poverty, abuse and neglect, violent crime, inadequate child care, lack of health care and environmental dangers. Visit **www.nsba.org/highlights/ten_threats_pr.htm**

Justice Matters Institute has a new interactive web resource on race, culture and equity in America's schools at **www.edjustice.org**

The Idea Box has great activity ideas for child care providers and families at **www.theideabox.com**

National Mental Health Association sponsors Childhood Depression Awareness Day on May 9, 2000. Call (703) 684-7722, e-mail childinfo *a* nmha org, or visit **www.nmha.org/children/green/index.cfm**

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A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

July-August 2000 Volume 13, No. 4

Safety tips for administering medications

Is it necessary to give medications or can the dosage be adjusted to before and after child care? Will a refusal pose significant hardship, especially if the child has chronic health conditions?

Do you have:

- Written permission from parent or legal guardian?
- The name and phone number of the licensed health professional who ordered the medication (on container or on file)?
- The original package/container or manufacturer's label and physician's directions for use and storage?
- The first and last name of the child on container?
- Current date on prescription/expiration label?
- A responsible person trained to give that medication?
- Appropriate documentation for administration of the medication?

NOTE *Remember to wash your hands before preparing medications and after giving medications.* ❖

The right call for poison help

by Elise Stone, MS, CHES, Health Education Coordinator, San Francisco Division, CA Poison Control System

As a child care provider or as a parent, do you know where to call when a child is poisoned? Did you know that Poison Control can provide help in more than 100 languages? Did you know that Poison Information Specialists are available 24 hours a day, every day, and that discussions are confidential?

This summer, "The Right Call for Poison Help" kit will be available. The information is targeted at parents of preschool children, who account for more than 50 percent of the nearly 900 calls received daily by Poison Control. The kit contains a video, instructional materials about Poison Control services, poison prevention tips, a parent handout and Poison Control telephone stickers. All materials are in English and Spanish.

The California Poison Control System will be donating hundreds of copies to WIC, Head Start, state preschools, Community Care Licensing, and Child Care Resource and Referral agencies. The kits may also be purchased for $25.00 from the California Poison Control System, UC San Francisco, Box 1262, San Francisco, CA 94143-1262.

This project was made possible by a $30,000 grant from the California Kids' Plates Program which funded a pilot program and the later revision and redesign of the materials. Generous donations from Kaiser Permanente and The Clorox Company contributed toward the reproduction of the program for general use throughout California.

For further information, call Linda Pope at the California Poison Control System at (559) 622-2304. ❖

Highlights of what's inside:

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Child Care Health Connections
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Volume 13, No. 4

Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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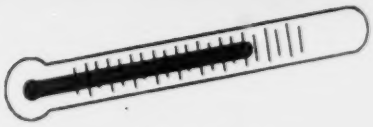
Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH



Q *I would like to be supportive of breastfeeding in my small family child care program, but I need more advice and information. Could you discuss this topic further?*

A The breastfeeding relationship between mother and child is unique and the most natural gift that a mother can give her baby. When a breastfeeding parent starts looking for child care, the provider needs to take time to discuss some important issues: How often does the infant nurse, and for how long? What relationship do the mother and child currently have? Is the mother ready to return to work? Can the infant use a bottle or cup and/or formula supplements? Gathering information before the child starts your program helps a provider with his/her scheduling and allows the mother to feel supported in her decision to continue breastfeeding after returning to work.

Keep in mind some of the advantages of breastfeeding:

- Breast milk provides all the nutrition a baby needs for at least the first six months of life and has advantages formulas cannot duplicate.
- Breastfeeding protects babies against some illnesses.
- Breastfeeding benefits infants with asthma and certain allergies by decreasing risks to their development.
- Breastfeeding may provide some protection against breast cancer.

Some ways you can help a breastfeeding mother feel comfortable about leaving a child in your care are:

- Learn what the mother wants to feed the infant. Many parents want their baby to be fed only breast milk, while others prefer both breast milk and formula.
- Learn how to store or use breast milk. (Call the Healthline for guidelines for storing and handling breastmilk.)
- Follow the parent's wishes by feeding the infant the way they want, always holding the baby.
- Try to time feedings to fit the mother's working and nursing schedule.
- Encourage the mother to come nurse her baby during the day. This will help the mother keep up her milk supply and give her special time with the baby during the day. ❖

Additional breastfeeding resources:

- Talk to breastfeeding mothers or contact resources such as *The Child Care Food Program* or the Healthline at (800) 333-3212.
- National Food Service Management Institute (NFSMI), **www.nfsmi.org**
- *Healthy Mothers - Healthy Babies, (202) 863-2458*
- *Nursing Mothers Council*, **www.nursingmothers.org**

Staying in touch with infant massage

Cheryl Oku, Infant Toddler Specialist

Infant massage is not new. Parents and caregivers in Asia, Africa and cultures around the world have made it a routine element of early child care for hundreds of years. Most babies love being held and hugged, and caring adults naturally use touch in caring for babies. It's free and easy to learn and practice during daily caregiving.

The benefits of infant massage reported to both baby and caregiver include the warm and positive relationships, relaxation and stress reduction, reduction of discomfort from colic and teething, less fussing and better sleeping. Recent research also indicates that massage provides benefits to premature infants.

July is Infant Massage Month. In the spirit of its celebration, here are some tips to get started:

- Find the right time and keep it short.
- Make it comfortable: Use a warm, safe, flat surface, such as a changing table or a blanket on the floor.
- Warm your hands, rubbing them with hand lotion or oil. Remove hand jewelry and keep nails short and smooth.
- Stroke gently and slowly, with a firm touch, as light strokes can tickle or irritate.
- Pay attention to the baby's signals. If s/he looks away or becomes cranky, try again later.

Start with some easy massages. A face massage can relieve tension accumulated from crying, sucking, teething and simply interacting with the world.

1. Using your thumbs, stroke the baby's face from the center of the forehead out to the temples and down the cheeks.
2. Draw your thumbs across the baby's nose and continue out across the cheeks.
3. Massage slowly around the mouth and jaw with your thumbs.
4. Use your fingers to stroke behind the ears.

The "I-love-you tummy massage" is especially comforting to babies with gas or constipation.

1. Use two or three fingers to trace the letter "I" on the right side of baby's stomach. Start under the ribs and go straight down to the hip joint.
2. Next, stroke left to right across the stomach, then a short downward stroke on the right side of the tummy again, to form a sideways "L".
3. To make the upside down "U", start at the baby's left hipbone, stroke up the left side of the tummy, across the tummy, then down the right side.

When <u>not</u> to massage. Do not massage babies if they have an unhealed umbilicus (belly button), a fever higher than 101 degrees, an infectious disease, a systemic infection, cancer or undiagnosed lumps, fracture, bleeding, burns or kidney disease. Always discuss care with parents.

For more information, check out *Infant Massage: A Handbook for Loving Parents* by Vila Schneider (Bantam Books, 1989). Or, check your local family resource center, parenting newsletters and resource and referral agencies for classes on infant massage.

Funding for the Infant/Toddler Specialist on the Healthline is from the Quality Improvement Program Plan, Child Development Division, California Department of Education. ❖

Caregivers and their (aching) backs

by Gail Gonzalez, RN

Editor's Note: *In our May-June issue, we discussed provider health. An important part of good self-care as a provider is taking care of your back.*

It doesn't matter the age of the children—child caring requires lots of physical activity. It involves sitting on the floor, lifting out of cribs and carrying something throughout the day. Toddler care requires lifting children up from a fall or down from a dangerous spot. Preschool rooms are frequently rearranged. School-age children need a master gardener, first-base umpire or Foozball opponent. Each activity can cause a strain to your body, and our most vulnerable spot is the back.

Maintaining yourself in good health and physical condition is the first step toward avoiding injury. Gentle muscle stretching and joint flexing before vigorous exercise should be routine. You and the children can make warm-up exercises the first thing you do when going out to the play yard. Warm muscles work better and have fewer incidences of injury. Including music makes it easier and enjoyable.

A job-specific concern for you is avoiding back injury. Lower back muscles are the most delicate muscles we have and they require special consideration. Learn and use proper lifting techniques. Practice resting one foot on a chair rung or low shelf when you will be standing.

(continued on page 11)

Child care and antibiotic use

by Lyn Dailey, RN

It is fairly common knowledge that young children are receiving more antibiotics these days, and that bacteria are becoming resistant to the antibiotics we have. What can you do as child care providers to reduce both of these situations?

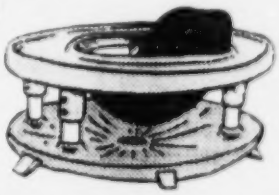
A 1998 Canadian study (*Archives of Pediatric and Adolescent Medicine 2000*; 154 180-183) looked at practices in child care centers serving infants and toddlers with upper respiratory infections (URIs) such as colds, cough and runny noses. Researchers surveyed centers for policies that exclude children with URIs, beliefs about the use of antibiotics, and how existing policies were enforced. Some of the findings include:

- 56% excluded children with colored nasal discharge
- 44% excluded children with a productive cough (one which produces phlegm)
- 26% thought antibiotics were useful for preventing the spread of URIs
- 21% thought antibiotics were useful for speeding the recovery from URIs
- 38% thought antibiotics were useful for preventing bacterial infections
- 69% reported making an exception to their exclusion policy for URI because a child had an antibiotic prescription

These findings are disturbing for a number of reasons. Primarily, many child care program providers did not understand how to reduce the spread of infections. Mild viral illnesses such as colds and flu are most contagious before the symptoms appear, and antibiotics are only effective against bacteria, not viruses. *Handwashing, cleaning and disinfecting, and personal hygiene will do more to stop the spread of URIs than exclusion will.* Exclusion for URI should be determined by the child's inability to participate in activities or the staff's ability to provide the level of care the child needs without endangering the other children. Secondly, programs that required antibiotic use to remain in care with a URI, or made exceptions to their own exclusion guidelines if the child was taking antibiotics, encouraged parents to seek out unnecessary antibiotics. *The decision to begin antibiotic therapy should be made by the child's medical provider, not the child care provider.*

The study acknowledges that many programs exclude children with URIs because of pressure from other parents who do not want their child exposed. Staff must be able to explain what steps they take to reduce the spread of infection, and why excluding the child with a URI will not protect the other children. Call the Healthline for a copy of the Health and Safety Notes, *Child Inclusion Exclusion for Illness* and *Runny Nose in the Child Care Setting.* ❖

Baby walkers: Are they good for physical and mental development?



by Rahman Zamani, MPH
Program Analyst

Although baby walkers are illegal in child care settings, many parents use them at home as a way of keeping their babies quiet and safe, while encouraging them to move around.

In fact, baby walkers—even the new, safer ones—hamper normal walking and healthy development. Research from the State University of New York at Buffalo and Case Western Reserve University have reported that use of baby walkers may slow physical and mental development. According to the research results published in the October 1999 issue of the *Journal of Developmental and Behavioral Pediatrics*, infants who used walkers had lower test scores on both physical and mental development.

The researchers think that use of newer-style walkers leads to physical developmental delays, such as the infant's ability to sit upright on his own, crawl and walk. The walker's large trays prevent infants from seeing their moving feet, depriving them of visual feedback that would help them learn how their bodies move through space. Baby walkers also prevent infants from exploring and grabbing at things around them, which is critical to their early mental development.

Taking into consideration the injuries from walkers and this new information on development, the researchers conclude that the risks of using walkers outweigh the benefits.

The American Academy of Pediatrics and other groups recommend that parents not use baby walkers. ❖

Using alternative medicine

by Rahman Zamani, MPH Program Analyst

The number of Americans using alternative medicine for themselves and their children is increasing. According to a study published in the Journal of the American Medical Association (JAMA), 40 percent of Americans in 1997 used alternative medicine, spent $27 billion out of pocket, and six out of 10 did not tell their physicians they were doing so.

Alternative medicine is also known as complementary, holistic, unorthodox and integrative medicine, and refers to most treatment practices not considered conventional, that is, widely practiced or accepted by the mainstream medical community. People often refer to these remedies as "alternative" if used alone and as "complementary" if used in combination with other alternative or conventional therapies.

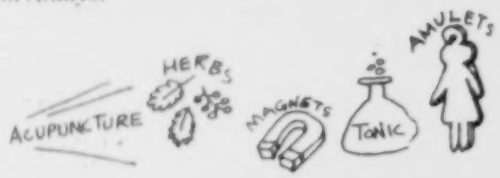
The widely known methods of alternative remedies are acupuncture, homeopathy, herbal medicine, chiropractic, massage therapy, naturopathy, relaxation therapy, aromatherapy, music therapy, megavitamins and traditional folk medicine. The most common is herbal medicine.

Although information on the use of alternative medicine by children is limited, a majority of pediatricians believe that some of their patients seek alternative care. Alternative medicine is an aspect of child health care that can no longer be ignored.

Some medical schools now teach alternative medicine due to its rising and widespread use. A growing number of hospitals and some health maintenance organizations offer alternative medicine treatment, and laws in some states require health plans to cover this alternative form of care.

Alternative methods of healing may be popular, but their scientific basis has not been established in most cases. The areas where alternative medicines seem to have most appeal are those where conventional medicine is not able to meet the need. Examples are chronic back pain, gastrointestinal problems, cancer, arthritis and eating disorders—health problems either caused or made worse by stress or emotional disorders.

The decision to use complementary and alternative remedies is an important one. As an informed health consumer, you need to consider the safety and effectiveness of the treatment, the expertise and qualifications of the health care practitioner, the quality of the service delivery, and the particular medical problem before selecting an alternative method of treatment. ❖



Things to consider

- As Congress in 1994 determined that "Dietary Supplements" were exempt from the regulations of the Food and Drugs Administration (FDA), the safety and effectiveness of herbal and alternative remedies are not monitored.
- The ability to understand the safety, effectiveness, indications for use and proper dosage of alternative remedies is important to avoid possible interaction or harmful delays in getting conventional treatment.
- Most untested herbal remedies are probably harmless and seem to be used primarily by healthy people for prevention or health maintenance. However, adulterants *(inferior and improper ingredients)* in some herbal products can cause poisoning. The herbal stimulant ephedra (also known as Ma Huang, epitonin or ephedrine and marketed as a safe and legal alternative) is known to have caused deaths.
- The *Medications Administration Policy* for your child care facility will also apply to Alternative Medicine. The administration of medicines should be limited to:
  - Prescribed medications ordered by a licensed health care provider for a specific child.
  - Nonprescription medications recommended by a health care provider for a specific child, with written permission of the parent or legal guardian, and instructions to the facility from a health care provider.

References: (1) *The National Center for Complementary and Alternative Medicine* (NCCAM) at The National Institute of Health (NIH), http://nccam.nih.gov. (2) *The New England Journal of Medicine (NEJM)* Sept. 17, 1998 Vol. 339, No. 12. (3) *The British Medical Journal* (BMJ) 1998, 317:1408 (21 November). (4) *Pediatrics*, December 1994

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HEALTH & SAFETY NOTES

California Child Care Health Program

Understanding and Caring for the Child with Attention Deficit Hyperactivity Disorder (AD/HD)

☞ What Is AD/HD?

AD/HD is a condition that causes children to have trouble paying attention, and to be overactive and impulsive. These behaviors often appear in early childhood and are not due to other physical, mental or emotional causes. About 20% of children with AD/HD also have learning disabilities.

☞ Diagnosis

AD/HD affects approximately 3 to 5% of *all* school age children. AD/HD is more common in boys and tends to run in families. Many children continue to have behaviors of AD/HD as adults. AD/HD affects all socioeconomic, cultural and racial backgrounds.

Diagnosis of AD/HD is a team effort and should include a pediatrician, psychologist, teacher(s), child care provider(s) and parents. The following behaviors are typically seen in children with AD/HD:

- makes careless mistakes
- has difficulty paying attention in tasks or play activities
- does not seem to listen to what is being said
- does not follow through or finish schoolwork or chores
- has difficulty organizing tasks and activities
- avoids or strongly dislikes routine tasks or activities
- is easily distracted and forgetful
- fidgets with hands or feet, or squirms in seat
- has difficulty playing quietly
- is "on the go" or acts as if "driven by a motor"
- talks excessively
- blurts out answers to questions before they have been completed
- has difficulty waiting in lines or waiting his turn
- interrupts or intrudes on others

All of these behaviors are "typical" for children at different ages and stages of development. For a child to be diagnosed with AD/HD, the behaviors must appear before seven years of age and have lasted for at least six months. The behaviors should be severe enough to warrant concern.

☞ Causes

Research suggests that AD/HD is caused by a chemical imbalance or a lack of certain chemicals in the brain which are responsible for attention and activity. There is also evidence that if one or both parents have AD/HD, their children will likely show symptoms as well. Exposure to toxins (including drugs and/or alcohol during pregnancy), brain injury and childhood illness may also cause AD/HD.

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Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

☞ TREATMENT

All interventions for children with AD/HD should build the child's sense of self-esteem. A team approach using educational, psychological, behavioral and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with AD/HD are typically "hands-on" learners who learn by doing and often will respond to:

- stimulating or novel activities
- lower adult-child ratios
- predictable environments
- individualized programming
- structure and consistency
- motivating and interesting curricula
- shorter activity periods
- use of positive reinforcers

Medication has been used successfully for children with AD/HD as a part of the treatment plan -- never alone. Stimulant medications have been found to improve attention span, impulse control and hyperactivity, with minimal side effects. Child care providers should work closely with families and health providers when a child is on medication and note any changes in behavior.

Counseling is important to improve the child's self-esteem, impulse control, compliance with taking medication and for addressing some of the behavioral issues. It is also helpful to have the family involved in the counseling or support groups, as AD/HD affects the whole family, not just the diagnosed child.

Physical activities can help the child with AD/HD to improve coordination and self-esteem.

Special diets are used to eliminate foods which may cause problems. Though there is no scientific evidence of specific foods or allergies causing AD/HD, many families believe that eliminating certain foods and taking certain vitamins have improved children's behavior and attention.

☞ EDUCATION

Children diagnosed with AD/HD *may* be eligible for special education and related services under the Individuals with Disabilities Education Act. Children who do not qualify for special education, but still need environmental or other modifications to the program and/or environment, may be eligible under Section 504 of the Rehabilitation Act or the Americans with Disabilities Act. For more information, children should be referred to and tested by the local school district to see if they qualify for services.

By Pamm Shaw, MS, Disabilities Specialist
With Lyn Dailey, PHN and Vella Black-Roberts, MPH
(November 1998)

References:

American Academy of Pediatrics (1994). *Understanding the ADHD Child: Information for Parents about Attention Deficit Hyperactivity Disorder*. Elk Grove Village, IL.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, revised, DSM IV). Washington, DC.

CHADD (1994). *Attention Deficit Disorder: An Educator's Guide*. 499 NW 70th Ave., #109, Plantation, FL 33317. (954) 587-3700.

Hallowell, E. and Ratey, J. (1994). *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. New York: Touchstone Books.

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Emergency medical ID offers an extra ounce of protection

by Charis Subil, PHN

Most of the time, accidents can be prevented with proper planning and precautions. Parents and caregivers would like to believe that they will always be there to protect their children. However, unforeseen events do happen, and quick access to emergency medical information could make the difference between life and death.

Emergency medical identification offers extra protection to children with serious medical conditions in the event of an accident or disaster. The easily recognized emblem is engraved with information about the child's condition and other important information.

Children with the following conditions should wear medical identification bracelets *(infants and young toddlers should not wear necklaces due to choking and strangulation risks)*:

- ***Severe allergies***: foods, medications, plants
- ***Serious medical conditions***: diabetes, thyroid problems, adrenal problems, blood disorders, heart conditions, seizure disorders, transplant recipients, suppressed immune systems
- ***Unusual blood types***

Organizations such as Medic Assist and MedicAlert offer a wide selection of emergency identification jewelry and other services. In addition to providing medical identification items, the nonprofit MedicAlert Foundation offers "The Children With Special Health Care Needs Program." When parents register a child with *MedicAlert*, an emergency medical information form is completed by the parent and physician. MedicAlert keeps a copy of the form on file in their 24-hour Emergency Response Center. The parents, physician, school nurse and child care provider also keep copies of the form. The form should be updated every two years or upon a change in the child's medical condition. In the event of an acute illness or injury, a health care professional can call *MedicAlert's* Emergency Response Center toll-free from anywhere in the world. Within minutes, a copy of the emergency form will be faxed to the provider.

Child care providers and parents must work together to ensure that children with potentially life-threatening conditions have that "extra ounce of protection" in an emergency. For more information, call:

MedicAlert *(800)432-5378 or www.medicalert.org/parents.html*

Medic Assist *(877)445-1404 or www.medicassist.com/*

Diversity

Diversity viewpoints

Life is often referred to as a journey, served more by the process than the destination. Our work on the Diversity Project has affirmed this belief as CCHP traveled along with providers and families this past year. We admire the strength and resiliency demonstrated on a daily basis as families try to resist the temptation to remain in the comfort zone. We are observing children find their way with a strong sense of identity, relaying both triumph and tribulation, feeling very enriched by their unique point of view.

Diversity specialist Paula Gerstenblatt said: "As the parent of two biracial children, I am keenly aware of the issues confronting biracial/biethnic children. These issues are similar for all children of color as well as any child who is distinguished by a difference of some kind. At times I am overwhelmed at the enormity of the work that remains in securing a future undaunted by that which makes us 'different,' one that values diversity and provides a level playing field in all the institutions that serve children and families. I am prone towards optimism as a result of my conversations with parents and child care providers, conversations that have touched my heart and provided a deeper understanding of what restrains or propels us towards transformation."

As we have much to teach our children, we have much to learn from them as well. They are our inspiration and a touchstone to understanding ourselves.

The Diversity Research and Training Project, so generously funded by the K. & F. Baxter family Foundation, has resulted in a curriculum for child care providers working with biracial/biethnic children that offers a training model and resources to truly make a difference in the lives of all children. CCHP applauds the efforts of all families and child care providers on behalf of diversity. In the coming year, it is our hope to continue working with the diversity community and community colleges using the curriculum to promote diversity among all California's child care community and the families they serve.

To obtain copies of the diversity curriculum, or for more information on the project, contact Rahman Zamani at the Childcare Health Program at rzamani*a* childcarehealth.org *or at (510) 839-1195.* ❖

Behavioral health

Oh, behave!

by Sandra Zehaye, MA and Pamm Shaw, MA, Disabilities Specialists, and Jennifer Smith, MA, Mental Health Consultant

***Editor's Note**: This article comes from the CCHP Behavioral Health and Special Needs teams to provide a context in which to view children's behavior. In this article we offer some guiding principles to address these issues and some tips on how they may be applied.*

1. All behavior is communication.

When a child hits, throws a toy and/or bites another child, s/he is communicating what s/he can't express in words. It is considered developmentally appropriate under certain circumstances for a 2-year-old to express anger, fear, frustration and power by biting or throwing toys. Yet these same behaviors are considered inappropriate for a 4-year-old child. For a young child to follow directions, s/he must be able to process the words and understand the meaning within the context of experience. S/he then must give some indication that the direction has been understood by giving a response—either through words or behavior. Children learn to "behave" from what they see, hear and feel by doing, trying and modeling what is demonstrated in their environment. By observing children's behaviors, providers can learn what may have caused the behavior as well as how to help children communicate their needs and emotions in more appropriate ways.

2. Build relationships.

Developing relationships with children and families is the most important job you have. By establishing nurturing, consistent relationships with children, you help them develop their sense of trust in the world. You show them that their world is a safe place, where they will be protected and have their needs met. Because the children in your program may spend the majority of their hours with you, you are in a powerful position to positively affect children's development and behavior.

The need for trusting, consistent, safe relationships applies to adults, too. Families need to develop positive relationships with you in order to work with you to provide the best care for their child. If you have already established a relationship with a family, discussing concerns about their child becomes much easier. Families will already know that you have their child's best interests in mind and that you value their role as parent(s).

3. Consider context (environment, culture, developmental and actual age).

Fairness vs. Equality: Equality means everyone gets treated the same. To be treated fairly means we each get what we need. Not every relationship is perfect. We don't all like the same foods, clothing, music or activities—so why should we be expected to like the same people? In the child care setting, not all caregivers are a match with all children. We can make accommodations to meet individual needs, but children, like adults, naturally sense and seek out the people who can meet their needs.

Temperament: The role of temperament (personality) is a consideration in understanding children's behavior and adult responses to it. People are different. Consider your personality and/or preferences. Do you go to sleep at the same time every night? Do you prefer to work alone or with others? Are you more comfortable watching the game or playing it? We have preferences for lifestyle and activities; we are drawn to certain adults or children who match our personality type. Know yourself, your preferences and what "pushes your buttons." Use this knowledge to build on your skills and improve your work with children and families.

4. Partner with parents in the process.

Parents know their children best. While your role as a primary care provider is very important, it is time-limited. You may care for a child for a month or several years, while parents and children have relationships that last a lifetime. Parents have the most powerful influence in their child's development and have the most invested in their well-being. However, sometimes parents need your help. While each of us is always doing the best we know how at a given time, sometimes we need more information or resources. Parents are the experts about their children, but you have knowledge about child development. Your combined expertise will enable you to provide the best care possible for children. By assisting families in the development of positive parent/child relationships, you give children and their families a gift that lasts a lifetime.

5. You don't have to do it alone.

You've tried everything to help facilitate learning for a child in your program. You've nurtured, redirected, hugged and met with the family, but the methods you tried didn't work. Not all of your strategies will be effective with every child. While involving families and respecting their values is crucial, you may sometimes

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Behavioral Health

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need to consult with other professionals who know about behavioral health, early intervention, physical health and other specialties. You don't have to be an expert in everything, but you need to know how to help children and families get the additional services they may need. For more information regarding resources within your community, you can contact your local Regional Center, school district, mental health department or call the Healthline at (800) 333-3212.

What you can do

- Remind parents how important they are in their child's life.
- Use teachable moments. For example, when a child or parent has a hard time with separation, acknowledge that it is difficult for both of them, so that the situation can reflect something positive.
- Ask parent(s) for their ideas regarding what works best with their child.
- Acknowledge and respect the family's cultural, ethnic and religious values.
- Provide consistent routines for children and parents. Prepare children for changes and transitions.
- Try primary caregiving: Have certain staff be the primary person for a particular child/family.
- Give children words/language for their feelings.
- Set appropriate boundaries and limits.
- Have one positive thing to say at the end of the day to parent(s) about their child.
- Accept that we are all doing the best we can and do not judge as you work toward positive changes. ❖

Changes to H&S training regulations

The Training Standards for Child Care Providers (Chapter 1.1, Division 9, Title 22 of the California Code of Regulations) were approved on Dec. 8, 1999. These regulations replaced the previous regulations, including the short-term emergency regulations.

One of the most important changes is the additional requirement that ***CPR training must now include adult CPR***. Contact the Healthline at (800) 333-3212 if you have questions about the new training regulations.

Consultant's corner

by Judy Blanding, PHN, MSN

Editor's Note: *It seems only fitting that we mark the new phase of child care health consultant expansion in California by creating a column where the counties and cities can report what they are doing, sharing their unique approaches. Our first guest writer is the "mother" of all health consultants in the state, Judy Blanding, PHN, MSN of the Maternal Child Adolescent Health Child Health and Disability Prevention Program in Santa Clara County. We honor Judy as part of the force behind the vision which created the California Child Care Health Program.*

The value of quality child care has finally come of age, and as a long-time child care health consultant (CCHC) it appears the "teachable moment" has arrived. Yet competing interests (e.g. violence prevention, health insurance, SIDS education) and new financial resources such as Prop 10 still hinder making the promotion of healthy child care a top priority and an opportunity for all levels of prevention. Here are some considerations, enabling CCHCs to partner, collaborate and lead, yet not get so stretched and fragmented as to lose sight of our identity or purpose.

- The CCHC is the resource of expertise regarding group health. Be visible in this role. As great as the child care setting may be, it is secondary if a child/staff is too ill to enjoy it. Delegate all other concerns as related professionals are linked and become available, e.g. mental health consultant will coordinate parent/staff classes in behavior management.
- Through collaboration, share how the CCHC can enhance the role and objectives of other health professionals, e.g. advice services delivered at a health department, or R&Rs referrals to county immunization or specialty clinics. Offer to write or coordinate a health article for your local R&R newsletter. Your article can highlight related programs such as mental health resources, or classes such as caring for children with special needs.
- When you have a goal, such as mandating health/safety education for child care providers, give it away to all interested parties. It won't materialize just as you may have perceived it, but with every handler's fingerprint on it you secured its passage.
- Be open to new directions: Encourage specific child care programs to become sites for specialized programs like gastric feedings, perhaps within an academic or community health system. Become a

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Aching backs

(continued from page 3)

for a long time. Have back support if you have to sit on the floor, and insist that there be some adult-sized chairs in your work space.

Sleep on your side or your back, not on your tummy. Learn the proper way to do crunches to strengthen your abdominal muscles. (Crunches are half-way sit-ups with your knees bent.) Building up abdominal muscles compensates for the weakness of the back muscles. Being overweight and having a large belly causes constant strain on the back. Losing weight and toning abdominal muscles will add to the strength of your back. A pregnant caregiver ought to discuss back health and her job with her health care provider as soon as possible.

A back injury is painful and inconvenient. It is one of the most difficult injuries to heal and can require a long recovery period when you may not be able to work or play. For your sake—and that of the children who love and depend on you—let's avoid that awful backache! ❖

Resources:

- *Facts About Backs*, National Safety Council, (630) 285-1121 or go to www.nsc.org
- *Exercises for Low Back Pain*: www.ultram.com
- Call the Healthline for additional resources, (800) 333-3212.

Health and safety calendar

July 13-16 ***Breaking Barriers: Working Together for Justice in Schools.*** Los Angeles. National Coalition of Education Activists. (914) 876-4580.

August is Medic Alert Awareness Month. Call (800) 432-5378 or go to **www.medicalert.org**.

August 1-7 ***World Breastfeeding Week.*** Contact La Leche League International at (847) 519-7730; **www.lalecheleague.org**.

August 7–8 ***12th Annual Northern CA Early Childhood Education Conference.*** Leading the Way to a Peaceful Tomorrow. Sacramento, CA. Call NCECE at (916) 263-0619.

August 18-20 ***Calif. Home=Education Conference.*** Sacramento, Home=Education. (916) 391-4942; www.HomeEdConference.com.

September 23–27 ***Family Violence—Working Together to End Abuse.*** San Diego. Children's Institute International. (310) 783-4677 or (213) 385-5100; **www.childrensinstitute.org**.

Legislative update

by Marsha Sherman, CCHP Director

The CCHP-sponsored bill, **AB561 (Romero) Child Care Health Linkages**, is still awaiting action by the Senate Appropriations Committee. We continue to work to assure that there is funding for the bill.

Three other legislative bills awaiting action in the Senate Appropriations Committee which will impact the health and safety of children in child care are:

AB443 (Mazzoni) This bill would establish the *Parent Services Project: Family Support in Child Care and Development Programs*, under which the Department of Education would award grants to centers to provide support to the families in their program. This project helps child care programs become a nucleus of resources, support and caring for families. CCHP will be working closely with this project.

AB1594 (Florez) This bill would require that all children be vaccinated against Hepatitis A, beginning July 1, 2001, before entering public or private child care or school.

SB1619 (Alpert) This bill would require that the Department of Social Services convene a working group to develop playground safety regulations specific to child care centers. The current recommended standards are for public playgrounds and do not meet the needs of child care centers.

Short letters to the chair, Patrick Johnston, could make a big difference! ***If they do not hear from you, they assume you do not care.*** Simply write a sentence or two as to why you care, and ask for the Senate's support to help protect our children. Address the letters to:

Patrick Johnston, Chair
Senate Appropriations Committee
State Capitol, Room 2206
Sacramento, California 95814

Consultant's corner

(continued from page 10)

visible partner with a home care organization to support insurance access. Through these partnerships CCHCs will become part of an integrated system providing services for children with special needs.

Collaboration is the way to accomplish our goal of promoting healthy, safe, integrated, family-friendly, high-quality child care. The job is too big for any single agency, and by sharing the responsibility, everyone learns. It does take an aware village of all related professionals to raise a healthy child. ❖

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Grassroots Success: Preparing School and Families for Each Other discusses 20 grassroots initiatives working to make "school readiness" a reality by bringing together families, schools and community. $8. National Association for the Education of Young Children. (800) 424-2460. **www.naeyc.org**

Online Resources

Better Kid Care Program offers satellite workshops. Check out their Web site at **http://betterkidcare.psu.edu/livesat.html**. If you missed a live broadcast, you can click on interesting topics for an archived copy and follow easy downloading instructions. Topics include: Active Kids Are Learning Kids, Hot Topics for Center Directors (Legal Issues), How to Take the Stress Out of Caregiving, Secrets of How to Get Parents Involved, How to Make and Use Puppets , What Brain Research Tells Us About Infant Care, When is Behavior OK or Not OK, and Taking a New Look at Dramatic Play.

Medication Administration Resources

The National Resource Center for Health and Safety in Child Care (NRC) offers states' licensing requirements regarding medication administration. Call (800) 598-KIDS or through their web site at **http://nrc.uchsc.edu/ca/ca_2_toc.htm**.

For Model Child Care Health Policies, visit the ECELS program at the Pennsylvania Chapter of the American Academy of Pediatrics web site at **www.paaap.org/ecels/model.htm**

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A health and safety newsletter for California child care professionals

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Graduate School of Public Health, San Diego State University

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Health & Safety Tip

Could a child in your care have Kawasaki Disease?

If a child has some combination of the signs and symptoms listed below,

- A fever that lasts five days or more
- Redness of the eye
- Redness of the mouth, lips, tongue and throat
- Swollen glands in the neck
- Extreme irritability

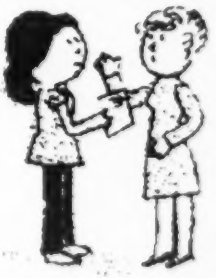
he or she could have Kawasaki Disease. Ask parents to take the child to a health care provider and ask if this illness could be Kawasaki Disease. With early recognition and treatment, full recovery can be expected.

Kawasaki disease was first described in Japan in 1967. It is now the leading cause of heart disease in children in the United States and occurs most frequently in children under 5 years of age. The cause of Kawasaki Disease is unknown.

For more information call the Healthline at (800) 333-3212. ❖

Let's talk about prescriptions

by Gail Gonzalez, RN



Giving medicines to other people's children can be a problem, unless you have a plan in place for your child care program. This plan would smooth out the wrinkles and allow you to have a clear vision of what is right for the child, the family and yourself. As a provider, you need to protect yourself and your program from doing harm, and from legal liability. Some providers address this problem by simply not giving medicines. This certainly protects them from legal liability, right?

If a child needs medication for a disability (a departure from her usual state of health), you *must* have practices to include him/her in your program (Americans with Disabilities Act 1990). So, it makes more sense to have provisions in place that will enable you to give medicines safely and effectively.

"Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out of Home Child Care Programs," published by APHA and AAP, recommends that you develop a policy which outlines exactly what you will do and how you will do it.

For example, XYZ Child Care Center will administer medications to children while they are in our care if:

- The medicine has been prescribed or recommended by a licensed health professional.
- The medicine is required during the times of attendance in the program.
- The medicine is clearly labeled by the pharmacist (or the parent for a non-prescription medicine), stating the name of the child, the name of the medicine, the name of the health care provider, the dose that should be given, the time it should be given and what days it is to be given.
- The parent fills out and signs a request to give medicine to the child.

And, you agree to:

- Store the medicine properly and safely away from children.
- Give the right dose, of the right medicine, at the right time, to the right child—and **write it all down each time you give the child medication.**
- Give the medicine back to the parent, and file the medication form in the child's file when the medication is no longer being given in child care.

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Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $20 per year. ***Newsletter articles may be reprinted without permission*** if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

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Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Charis Subil, RN, PHN

QUESTION:

As a new family child care provider, I'm nervous about checking immunization records and learning all of the requirements. Help!

ANSWER:

Your concern about checking immunization records is understandable. New vaccines are frequently being introduced and requirements often change. Whenever young children are in a group setting, there is an increased risk of spreading communicable diseases. Infants and toddlers are the most vulnerable to these sometimes fatal diseases, such as Pertussis (Whooping Cough) and Haemophilis influenzae B Meningitis (HIB).

Provider checklist for immunization review

NOTE: The child care provider is only required to review immunization records for children younger than school age. When the children are in school, the school must review the records.

- Obtain "School Immunization Record" cards and a pink "Windows for Immunizations" template from your county immunization program or resource and referral agency (the same form is used by elementary schools and child care).
- Prior to admission, ask parents to show you an official immunization record that includes the month/day/year of each immunization, usually a "Yellow Card," signed by a health care provider.
- Transfer the immunization information for each child onto a Blue Card; sign and date the "Documentation" section.
- Check the Blue Card using the pink "Windows for Immunizations" template; circle the missing immunizations.
- Admit the child into care if the immunizations are current. Determine when/if the next immunizations are due and set up a system for notifying parents.
- If the child's immunizations are not current, inform the parent that the child will need to be immunized prior to admission. Write down missing vaccinations. Refer the parent to the medical provider or, if necessary, to the local immunization clinic.
- Parents may claim an exemption for personal or religious reasons. They must sign the affidavit on the reverse side of the Blue Card. A written statement from the health care provider is required for medical exemption.
- Fill in the "Status of Requirements" section on the blue card.
- It is not necessary for child care providers to fill out the TB skin test section. (Children must be screened by their medical provider to determine the need for a tuberculin skin test.)

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Infant/Toddler care

Prevent choking!

by Cheryl Oku, Infant/Toddler Specialist
Funded through the Quality Improvement Program, Child Development Division, California Department of Education

When infants become mobile and start eating table foods, caregivers and parents must stay alert to prevent choking. Food and other common objects can easily become choking hazards for children under 4 years of age.

When food or small objects block the airway, oxygen cannot get to the lungs and the brain. Four minutes without oxygen can cause brain damage or even death. Although many children die from choking each year, the American Academy of Pediatrics (AAP) and the American Heart Association (AHA) believe that caregivers and parents can often prevent choking.

Dangerous foods. Do not feed children younger than 4 years of age any round, firm food unless it is cut into tiny pieces. When infants and young children don't grind or chew their food well, they may attempt to swallow it whole. The following foods can be choking hazards: hot dogs, nuts, chunks of cheese or meat, whole grapes, hard or sticky candy, popcorn, globs of peanut butter, raw carrots.

Dangerous household items. Keep the following items away from infants and toddlers: plastic bags, balloons, coins, marbles, small toy parts, pen and marker caps, plants, small batteries, small compressible toys that can fit into a child's mouth.

What you can do to prevent choking:

- Make sure children eat while sitting down. Running, walking or playing with food in the mouth is a major cause of toddler choking.
- Cut food for infants and toddlers into ¼- to ½-inch pieces and teach them to chew their food well.
- Sit at the table during mealtimes to model good eating habits and monitor for unexpected hazards.
- Be sure parents who provide snacks or meals are aware of dangerous foods.
- Avoid toys with small parts and keep other small items out of children's reach. If you are not sure whether a toy is safe, use a safety tube* to check. Remind parents and other adults to keep purses, backpacks and other bags out of children's reach as they often contain hazardous items.
- Stay informed about new hazards through resources such as the Consumer Product Safety Commission Alerts. To sign up, go to www.cpsc.gov/cpscpub/prerel/prerel.html and click on CPSC's e-mail subscription list.
- Learn and practice infant and child CPR. Encourage parents to learn choking first aid, perhaps by offering a training for them.

Adapted from an article by the American Academy of Pediatrics, 2000.

*Educational suppliers such as Lakeshore, Kaplan, or Environments carry no-choke testing tubes. Or use a standard cylinder with an inside diameter of 1-¼" and a depth varying from 1 to 2 ½" to see if the part is safe. ❖

Health consultant's corner

by Lyn Dailey, PHN
Child Care Health Consultant, CHP

The California Child Care Health Program (CCHP) looks forward to beginning the ***Child Care Health Linkages Project*** in the coming months. The California Children and Families (Proposition 10) Commission will fund the implementation of child care health consultant and family health coordinator services in a number of counties, to be administered by CCHP. A Request for Applications (RFA) will be mailed to every local Prop 10 Commission, child care resource and referral agency, city and county child care coordinator, AEYC chapter, child care planning council, maternal and child health director in public health departments and child development chair in community colleges. A single application will be accepted from each county (or SPA in Los Angeles only) to ensure optimum collaboration among programs serving children up to 5 years of age. Please call Lyn at (510) 281-7907 for more information or to request an application.

The positions of child care health consultant and family health coordinator have many important implications for the work we have been doing as health consultants over the years (decades, for some). We will have a network of health and child development professionals throughout the state addressing similar issues from similar perspectives and with some standardized training from which to work. The promotion and adoption of the "National Health and Safety Performance Standards for Out-of-Home Care Settings" will result in consistent messages and education for child care and development programs. We will be using this column to highlight the struggles, successes and lessons learned as such a

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The cook, the housekeeper, the volunteer and the licensing analyst

by Lyn Dailey, PHN

We frequently stress the importance of infection control in child care settings and we usually address these points to the caregivers. Classroom teachers and family child care providers play a huge role in stopping the spread of infectious disease in their programs. Yet diapering, toileting, wiping runny noses and handling toys are prime ways caregivers can help spread bacteria, viruses and parasites from one person to another. Whom might you be overlooking as you inspect your infection control efforts?

The cook and other food service staff have many opportunities to spread disease, especially if they change any diapers (which they shouldn't, if at all possible). Sanitation of food storage, handling, preparation and feeding practices must be strict and monitored for compliance. Passing out snacks is just as much part of food service as is cooking a full lunch. Don't overlook teachers and classroom volunteers when training staff on food safety.

The housekeeping staff may do their work when the children and most staff are gone, but they also play a role in infection control. Do they use the same disinfectant products you use? Do you know their cleaning schedule and do they know yours? Do they understand the importance of washing their hands after using the toilet? Are they included in your staff training on cleaning and disinfecting? Be sure they are fully immunized and TB-tested if they provide services when children are present.

Parents, visitors and other volunteers must know that they are expected to wash their hands at the same recommended times as staff and children. Make it a practice to welcome them to your program by greeting them and directing them to the handwashing sink. Children can act as "handwashing ambassadors" when visitors arrive. Do you have an "*All visitors must sign in*" poster? Add "and wash their hands" to it if you do.

The licensing analyst who performs your site visit can't be overlooked. Just imagine how pleased they will be when you ask them to wash their hands and sneeze into their elbow.

The children you care for are perhaps the most important link in this chain of disease transmission. This is why you are charged with making sure they are up to date on their immunizations and stay home when they are ill to protect others. Staff must wash infants' hands after diapering and supervise the handwashing of older children. Teaching hygiene to young children is not enough; handwashing practices must be supervised, modeled and monitored by an adult. ❖

Recommendations for the use and handling of toothbrushes

by Rahman Zamani, Program Analyst

Although it is sometimes difficult, brushing teeth in the child care setting helps children develop lifelong preventive habits, maintain oral health, and prevent tooth decay and gum disease. To ensure that toothbrushes are not contaminated, and to prevent the spread of infection from germs found in saliva and blood, child care providers need to follow common sense and proper hygiene procedures. The child care provider must assure that the following procedures—with sufficient supervision—can be built into the regular schedule when they begin planning toothbrushing protocol.

Using toothbrushes

- Always supervise children when they are brushing their teeth.
- Each child should have his/her own toothbrush.
- The toothbrushes and storage container should be clearly labeled with the child's name.
- Do not allow children to share or borrow toothbrushes.
- Use a pea-sized amount of fluoride toothpaste. Make sure parents know which toothpaste you use.
- Instruct each child to brush teeth properly, spit out the toothpaste, and rinse mouth with water.

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Oral disease: The silent and neglected epidemic

by Rahman Zamani, Program Analyst

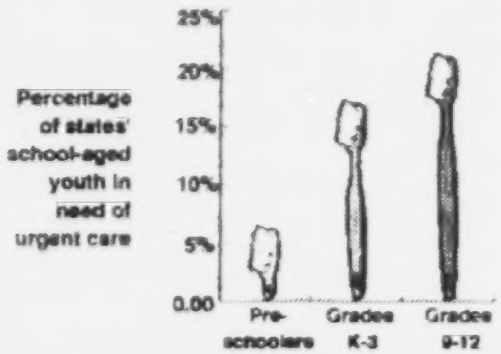
Oral and dental diseases are the most common and the least treated of childhood diseases. The first-ever report by the Surgeon General on oral health in America, released on May 25, 2000, refers to a "silent epidemic of dental and oral disease that disproportionately affects some population groups," and calls for a national effort to improve it.

The first statewide oral health needs assessment ("The Neglected Epidemic"), published by the Dental Health Foundation in 1997, revealed that California's children have twice as much dental disease as the national average. In April, a San Ysidro Health Center survey of 2,000 preschool children in South Bay, CA found that about 65 percent of the children had untreated dental disease.

Tooth decay and gum disease are the two major oral health problems. For many children, dental disease interferes with eating, sleeping, speaking, playing, learning and smiling. It is also responsible for children missing millions of school hours each year, especially low-income children and children of color, who have poor access to preventive dental care and are thus more vulnerable. Gum disease, which may cause tooth loss, is now linked to heart attack, stroke, respiratory diseases and pre-term babies.

Oral diseases are almost entirely preventable. However, more than 25 percent of California preschool and elementary school children and more than 40 percent of high school students have no dental insurance; even the 40 percent of children who have medical insurance have no dental insurance. The following resources could help cover the expense of children's dental care:

- ***Medi-Cal*** : (888)747-1222
- ***Transitional Medi-Cal :*** (888) 747-1222
- ***Healthy Families:*** (888) 880-5305
- ***CHDP:*** (888) 604-4636
- ***California Kids:*** (888) 335-8227
- ***Community-sponsored programs:*** Some clinics, dental societies, nonprofit organizations, churches, dental schools and private practitioners have services that provide free or lower-cost care to families in need. ❖



Reprinted with permission from the California Fluoridation Task Force.

Tips for preventing oral disease and infections:

- ***Cleaning teeth and gums*** is the single most important way to prevent dental and gum disease.
- ***Good nutrition***, which is good for the body, is also good for the mouth. The most harmful foods are those containing sugar.
- ***Regular dental visits*** will ensure early detection and correction of oral/dental problems. If not previously referred by a health care provider, children should get regular dental checkups by a dentist or pediatric dentist after age 3.
- ***Use of fluoride*** reduces tooth decay. Research shows that fluoride reduces cavities by up to 50 percent in children. Toothpaste and drinking water may have fluoride. It is suggested that only children between 6 months and 16 years of age living in non-fluoridated areas use additional fluoride prescribed by a dentist or health care provider.
- ***Use of sealants (plastic coatings applied to teeth by a dental professional)*** will help prevent tooth decay by creating a physical barrier between the teeth and plaque and food. Since permanent molars are the most at risk for decay, the six-year and twelve-year molars need sealants.
- **Using mouth protectors** prevents oral/dental injuries among children involved in recreational activities such as soccer, hockey, football and even bicycling and rollerblading. "Stock" mouth protectors are available in stores, and a better-fitting variety can be custom fitted by your dentist.
- ***Prevent baby bottle tooth decay***, which can occur when a child is frequently exposed to sugary liquids such as milk, including breast milk, fruit juice and other sweet liquids.
- ***Learn how to handle dental emergencies:*** You can help a child avoid losing a tooth.
- ***Help parents find a dental provider*** in their area.

(See page 12 for online dental resources.)

"UNIVERSAL PRECAUTIONS" IN THE CHILD CARE SETTING

☛ **WHAT ARE THEY?** "Universal Precautions" is the term for infection control measures all health care workers and child care providers should follow to protect themselves from infectious disease.

☛ **WHAT DO THEY CONSIST OF?** The Occupational Safety and Health Administration (OSHA) requires workers who might come into contact with blood and other body fluids (such as stool, urine, vomit, draining wounds) to practice the following:

1. **Handwashing**
   - after diapering or toileting children
   - after handling body fluids of any kind
   - before and after giving first aid (such as cleaning cuts and scratches or bloody noses)
   - after cleaning up spills or objects contaminated with body fluids
   - after taking off your disposable gloves

2. **Latex Gloves** should be worn by all people
   - when they come into contact with blood or body fluids which contain blood (such as vomit or feces which contain blood you can see)
   - when individuals have cuts, scratches or rashes which cause breaks in the skin of their hands

Remember: wearing gloves does not mean that you don't have to wash your hands!

3. **Environmental Disinfection** should be done regularly and as needed. In the child care setting this means cleaning toys, surfaces and diapering areas with a bleach solution (1 tablespoon of bleach per quart of water made fresh daily). Blood spills or objects with blood on them need a stronger solution of ¼ cup bleach to 2 ½ cups water. *Wear gloves when handling blood.*

4. **Proper Disposal of Materials,** which are soaked in or caked with blood, requires double bagging in plastic bags that are securely tied. Send these items home with the child, or if you wash them, wash them separately from other items. Items used for procedures on children with special needs (such as lancets for finger sticks, or syringes for injections given by parents or children) may require a special container for safe disposal. Parents can provide what is called a "sharps container" which safely stores the lancets or needles until the parent can take them home.

☛ **WHY ARE THEY NEEDED?** Germs that are spread through blood and body fluids can come at any time from any person. You may not know if someone is infected with a bacteria or virus such as hepatitis or HIV; the infected person himself may not even know.

This is why you must behave as if ***every*** individual might be infected with ***any*** germ in ***all*** situations that place you in contact with blood or body fluids.

California Child Care Health Program •1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
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Following the steps listed above will result in practicing ***Universal Precautions***, and will help protect you from getting "bloodborne pathogens" (disease carried by blood and other body fluids) in the child care setting.

➨ **WHAT ELSE AM I REQUIRED TO DO?** OSHA also requires that all child care programs with staff (even family child care homes with assistants or volunteers) have an ***Exposure Control Plan for Bloodborne Pathogens***. This plan must be in writing and include:

1. **Exposure Determination,** a list of the job titles or duties which might put an individual in contact with blood or blood-containing fluids (such as "first aid," "nose blowing," "diapering," etc.)

2. **Methods of Compliance,** the ways you will assure your plan will work and which include written universal precautions and cleaning plans, training of staff in their use, and the availability of gloves.

3. **Hepatitis B Vaccination** must be offered by the employer ***at no cost to staff.*** The vaccine series can begin either

   - Within 10 days of employment, or
   - Within 24 hours after a potential blood exposure (first aid, diapering a bloody stool, etc.)

Note: Hepatitis B is a series of 3 shots, which must be given on a specific schedule. Now that all children are required to have the series before entering care, child care providers should be at a reduced risk of getting hepatitis B in a child care setting.

4. **Exposure Reporting Procedures:** These are required and will tell staff what to do if something happens which puts an employee in contact with blood on their broken skin (cuts, scratches, open rashes or chapped skin) or on their mucous membranes (in the eye, mouth, or nose). There are also record-keeping requirements to document the exposure situation, whether or not the employee received a free medical exam and follow-up, and that the employee was offered the hepatitis B vaccination if she/he has not had the series.

5. **Training on OSHA Regulations** must be provided to all staff at the time that they start work. This must include:
   - An explanation of how HIV (causes AIDS) and HBV (causes hepatitis B) are transmitted
   - An explanation of Universal Precautions and the exposure control plan for your program.

For more information on OSHA requirements, contact the Cal/OSHA Consultation Service office listed in your telephone directory, or call the Healthline at 1-800-333-3212 for a referral to the office nearest you.

References: Caring for Our Children, National Health & Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, American Public Health Association and American Academy of Pediatrics (1992), Washington D.C.
CalOSHA Regulations on Bloodborne Pathogens, Child Care Law Center (1994), San Francisco, CA

By Lyn Dailey, PHN (4/20/98)

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Diversity

by Rahman Zamani, Program Analyst

Traditional practices can affect the health of children

Working with multicultural and multiethnic children and families can be both rewarding and challenging. One of the challenges is providing quality care to children and families who have different and sometimes conflicting health and illness beliefs and behaviors from your own. In addition, values regarded as positive in one culture may be considered negative in another.

While Western medicine increasingly recognizes the benefits of some traditional medical practices such as acupuncture, yoga and spiritualism, we also know some practices may be harmful to health and wellbeing, and may even be considered child abuse and irrational from the scientific point of view. Examples of harmful traditional practices include female genital mutilation or female circumcision, which can have critical, long-term physiological, sexual and psychological risks; cupping, coining, scarring and burning of skin causing pain and scars; use of some poisonous traditional herbal or home remedies including arsenic, lead and mercury; nutrition taboos and practices related to child delivery; and a low level of breastfeeding.

Sometimes a harmful practice has deep cultural roots. However, most people will change their behavior when they understand the risks of these practices, and especially when they realize it is possible to give up harmful practices without giving up meaningful aspects of their culture.

Most people will change their behavior when they understand the risks of harmful practices.

Lack of cultural awareness may cause miscommunication and misunderstanding between providers and the families they serve. A traditional remedy may be confused with intentional child abuse or may interact negatively with modern medication. It's important to know the traditional health-related practices of families you are serving and be sensitive to their beliefs, as they play a significant role in individuals' lives. Emphasize the positive points and the strengths of health beliefs/practices, and don't discredit them unless you know they are harmful.

Flexibility, open-mindness, and the ability to establish trust and willingness to learn are all important qualities when serving children and families of different cultural/ethnic groups.

For more information on any of these potentially harmful traditional practices, please contact the Healthline, (800) 333-3212. ❖

Announcing a new publication by the California Child Care Health Program in September, 2000:

SERVING CHILDREN IN BIRACIAL/BI-ETHNIC FAMILIES

A Supplementary Diversity Curriculum for the Training of Child Care Providers

Addressing the needs of children from all combinations of race and ethnicity

Topics Included:

- Ages and Stages of Identity Development
- Identifying and Responding to the Unique Needs of Biracial/Bi-Ethnic Families
- Racial/Ethnic Labeling
- The Impact of Environmental Factors on Biracial/Bi-Ethnic Children
- Ensuring Cultural Sensitivity in Child Care
- Integrating Materials and Activities
- Organizations, Videos, Multicultural/Anti-Bias Curricula, Bibliography and Website Resources

Limited copies of the curriculum are available by contacting the California Child Care Health Program at (510) 839-1195 or emailing us at chp *a* dnai.org.

Inclusion insights

Do I have the tools?

by Pamm Shaw, MA and Sandra Zehave, MA, Disability Specialists

Thank you! We received more than 1,000 survey responses from parents and providers to document the issues related to children with special needs in child care. The report being prepared for the California Department of Education, Child Development Division will be richer because of your time and effort. The need for training and information for both parents and providers was clearly indicated.

With the child care population growing more diverse, provider training is a necessity, and reliable information shared between provider and parent is just as important. Each day providers welcome families into their program who may need more services than they alone can provide. Some parents openly share all the information they believe the provider will need to properly care for their child, and others struggle with sharing any information beyond what is asked.

Letting families know that your program welcomes and celebrates the diversity of all children creates opportunities for parents to share information without the fear of being rejected.

Both providers and parents recognize the need to work together and support each other for the good of the child and community. Letting families know that your program welcomes and celebrates the diversity of all children creates opportunities for parents to share information about their child without the fear of being rejected by the program. Seeing for themselves what inclusion means encourages parents to discuss frustrations, concerns and their child's development. Together, you can develop a plan for the child within your program.

Sometimes the family's home can be the most appropriate place to discuss a child's needs. Often things are shared in a family's home that would not otherwise be shared at the center or the provider's home. Home visits can be a valuable tool for providers to understand the family through their cultural and home environment and to observe the child there.

More detailed information will follow in future newsletters. ❖

Health and safety calendar

September

11-12: ***Strengthening Programs Through Blended Funding and Action Planning***. Redding. Northern California Child Abuse Training and Technical Assistance Center, Sonoma State University. (707) 664-3062; www.sonoma.edu/cihs/catta

23-27: ***Fifth International Conference on Family Violence: Working Together to End Abuse***. San Diego. Family Violence and Sexual Assault Institute, 6160 Cornerstone Ct. East, San Diego, CA 92121; (858) 623-2777; www.fvsai.org.

October

National Breast Cancer Awareness Month. Take care of yourself and check out the Breast Cancer Resource Center on the American Cancer Society Web site at www.cancer.org (click on *Breast)* or call (800) 227-2345.

4: ***Early Intervention Feeding Issues***. Early Learning Institute, Rohnert Park. (707) 591-0170, earlylearningrp@aol.com

7: ***20th Annual Conference: Our Children, Our Vision, Our World***. Tri-Cities Children's Centers, Fremont. (510) 744-9280 x18; www.childrensservices.org.

10-13: ***16th Annual Child Development Division Conference***. Anaheim. CA Dept. of Education, Child Development Division, Sacramento. (916) 322-6233; www.cde.ca.gov/cyfsbranch/child_development/cddconf.htm.

20-21: ***20th Annual California SIDS Program Conference***. Costa Mesa. (800) 369-SIDS, (800) 369-7437.

23-25: ***Childhood Injury Control Conference***. Sacramento. Center for Childhood Injury Prevention. (619) 594-3691, email kmjones@mail.sdsu.edu or visit www.injuryprevention.org/cccip/cccipconf.htm.

29-31: ***2000 California Child Care Resource and Referral Network's Annual Conference***, Pacific Grove. (415) 882-6233.

November

8-11: ***National Association for the Education of Young Children Conference***. NAEYC, Atlanta, GA. (800) 424-2460; www.naeyc.org/conferences/annual/2000/zocalo.htm

Behavioral Health

Early childhood mental health: The importance of relationships

Jennifer Smith, MA, Behavioral Health Specialist

Early childhood mental health refers to a child's wellbeing and best possible social/emotional development. It emphasizes the interaction and exchange between a child and the significant caregiver(s) in his/her life, the patterns of relating that develop and what the child is learning through these interactions. Think of it as a dance between two partners. Children give us cues, we respond and they react to our responses. The foundation for early childhood mental health lies in the quality of early primary relationships.

Development of "self"

A child develops a sense of self through early relationships with the primary people in her life. The ways in which the significant caregiver(s) meet or do not meet the child's needs shapes how she sees herself and her expectations. For example, if a child becomes frightened by a loud noise, she may cry and seek out her primary caregiver. If this caregiver's voice or touch soothes the child, she learns that her world is a safe place where her needs will be met. If she received no response or was made to feel badly about being scared, she gets the message that her world is not a safe place or one where her feelings will be valued.

The messages a child receives over time impact whether or not he develops trust in the world. He learns what to expect from the world and how to relate in it. Imagine a blueprint for a new house. The blueprint shows where the front door is, the route to the kitchen and how many rooms there are. For children, the early patterns of interactions and the messages those interactions convey, become their blueprints for relationships with others. Dr. Louise Kaplan says it this way: "A baby gets to know what he is by what is mirrored in the faces of those who look at him."

Brain development

Early relationships also affect brain development. Research shows us that children growing in stimulating and emotionally nurturing environments have different brain structures than those developing in neglected or abusive settings. Pictures of the brain show us that loving, trusting early relationships are important for our emotional development and wellbeing, but also for the physical development of the brain. Connections between various parts of the brain have the best chance for development when a child has a primary caregiver(s) who understands her cues and responds in a way that meets her needs. At birth, an infant's brain weighs 25 percent of an adult's. At 36 months, it weighs 90 percent of an adult's brain. A tremendous amount of brain growth occurs in a child's first three years, a combination of the child's biology and environment. When child and caregiver(s) interact, the child's brain fires off messages which connect to other parts of the brain. The more connections made, the more developed the brain becomes. Some children with behavioral difficulties may have inadequate development of the parts of their brain which regulate their ability to control impulses and understand others' feelings.

Because early relationships impact our physical, social and emotional development, they affect us throughout our life span. ❖

Product watch

Playtex Pacifiers. Playtex is recalling its latex pacifiers sold under the product names Playtex Classic Patterns and Playtex Soft Comfort because the latex used in these product lines may age faster, and the nipples could become dry or cracked and separate from the shields, which could pose a choking hazard to young children. The word "Cherubs" appears on the shield of the Classic Patterns pacifiers, and Soft Comfort pacifiers have a soft, butterfly-shaped shield. For more information, call Playtex at (800) 522-8230.

Gerry® TrailTechTM Backpack Baby Carriers with plastic frames are being recalled because small infants can shift to one side, slip through the leg openings of these carriers and fall. Consumers should stop using these backpack carriers immediately, and call Hufco-Delaware at (800) 881-9176 anytime for a free repair kit that replaces the seat of the carrier.

Plush Shape Sorters and Stacking Toys by Gymboree are being recalled. The stuffing of the toys can contain sewing needles and sharp metal pieces. Young children must stop using the toys immediately. Return them to the store where purchased for a refund. For more information, contact Gymboree at (800) 222-7758 between 9:00 a.m. and 5:00 p.m. PT Monday through Friday.

Stand-Up 'N Play Tables by Shelcore Inc. are being recalled to replace the xylophone mallets. The mallet that comes as part of the set can become lodged in the throats of young children, posing a choking hazard. Consumers should immediately throw the recalled mallets in the trash, and call Shelcore for a free replacement mallet. For more information, call Shelcore at (800) 777-0453 between 9 a.m. and 5 p.m. ET Monday through Friday. ❖

Health consultant

(continued from page 3)

network develops. Please submit your stories, questions, anecdotes and testimonials to the California Child Care Health Program for consideration of publication in this newsletter. Submissions may be faxed to (510) 839-0339, e-mailed to ldailey@childcarehealth.org, or mailed to 1322 Webster Street Suite 402, Oakland CA 94612-3218.

We look forward to sharing these stories and experiences with our readership throughout the year. ❖

Toothbrushes

(continued from page 4)

Toothbrush storage

- Toothbrushes should be well cleaned (rinsed with water) after use, whenever possible. Never "disinfect" toothbrushes.
- Store each toothbrush so it cannot touch any other toothbrush, and allow it to air dry.

Toothbrush replacement

Replace toothbrushes:

- Every three to four months or sooner if bristles have lost their tone.
- If a child uses another child's toothbrush, or if two toothbrushes come in contact.

If a child uses the toothbrush of another child who is known to be ill or to have a chronic bloodborne infection (such as Hepatitis B or HIV), parents of the child who used the ill child's brush should be notified. ❖

Adapted from information by the Centers for Disease Control and Prevention (CDC).

More toothbrushing tips

- To prepare brushes for several children, place pea-sized dabs of toothpaste on a sheet of paper a few inches apart. As each child hands you his toothbrush, the toothpaste can be quickly applied.
- Or, try putting a dab of toothpaste on the bottom of a paper cup. The child then puts this on her toothbrush and uses the cup to rinse.
- Check with your dentist for help obtaining toothbrushes at low or no cost.

Ask the nurse

(continued from page 2)

- Keep Blue Cards in an organized file and review monthly.

For questions concerning immunizations, help setting up a notification and monitoring file, or help reading immunization schedules, call the Healthline at (800) 333-3212. ❖

Immunization updates:

Polio vaccine: now given by a shot (IPV) instead of by mouth (OPV).

Varicella vaccine (chickenpox): **required as of July 1, 2001** for both child care and school entry (one dose on or after the first birthday).

Hepatitis A vaccine: highly recommended (but not required) for California children ages 2 and older.

Flu vaccine: often recommended for children with chronic medical conditions; must be determined by a health care provider.

Other resources:

National Immunization Hotline: (800) 232-2522 (English), (800) 232-0233 (Spanish)

NIP Home page: http://www.cdc.gov/nip/

Immunization Branch, CA Dept. of Health Services, (510) 540-2065

Prescriptions

(continued from page 1)

We recommend that you have plans for the different ways of giving medicine properly, whether by mouth, on the skin, drops in ears, eyes, nose or mouth, or inhaled. Some medicine delivery systems require training ahead of time.

Call the Healthline (800) 333-3212 for resources to help you write your policies. When you are sure that you have all the pieces you need to administer medicines safely to the children in your care, ask your lawyer to review your plan for protection from liability or get some legal advice from the Child Care Law Center (415) 495-5498. ❖

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Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

SIDS Prevention Contact CPSC at (800) 638-CPSC. For a free copy of "Safety Tips for Sleeping Babies," visit www.cpsc.gov or write to CPSC, Washington, DC 20207.

Early Childhood Intervention Programs: What Do We Know? Provides summarized cost/benefit research showing that investing in quality early childhood programs for disadvantaged preschoolers has significant long-term benefits. Joint Center for Poverty Research, Northwestern University, 2046 Sheridan Rd, Evanston, IL 60208; (847) 491-4145; www.jcpr.org/conferences/oldbriefings/childhoodbriefing.html

Partnering for Success: Community Approaches to Early Learning presents 68 partnerships between schools and child care organizations that work to ensure greater access to quality child care so children enter kindergarten ready to learn. Child Care Action Campaign; (212) 239-0138; www.childcareaction/org/rpubs.html

Immigrant Access to Health Benefits explains basic eligibility requirements for key federal and state programs and identifies potential barriers. Free from The Access Project; (617) 654-9911; www.accessproject.org/resource/

Online Oral Health Resources

American Dental Association www.ada.org

The American Academy of Pediatric Dentists www.aapd.org

American Academy of Pediatrics www.aap.org/family/dental.htm

The Maternal and Child Oral Health Resource Center www.ncemch.georgetown.edu/oralhealth/OHRsrc.html

American Association of Public Health Dentistry www.pitt.edu/~aaphd/

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A health and safety newsletter for California child care professionals

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November-December 2000 **Volume 13, No. 6**

Be smart— Keep foods apart

by Gail Gonzalez, RN

When food safety professionals say "Don't Cross-Contaminate!" What does this mean to you? It means if you put your fresh vegetables in the same bag with your raw chicken, the juice may mix with the vegetables and cross-contaminate them. Now the vegetables could grow bacteria and cause the same illness raw chicken can—and you don't even suspect it. Cross-contamination can happen in your grocery cart, in the refrigerator, with a knife, on the cutting board, in the marinating tray or on your plate.

In child care, many people handle the children's food, so it is important that everyone know how to avoid cross-contamination. If you have a catering service, be sure staff are supervised and food inspected carefully to assure that cross-contamination doesn't happen there. If you don't have a catering service, examine your own procedures and think of all the people who may handle food in a day: the person who shops, cooks, serves or transports the food, the children themselves and parents who bring food. Think about field trips, cooking projects, picnics and outdoor snacks. The opportunities to cross-contaminate are numerous and frequent.

(continued on page 11)

Twenty percent of SIDS deaths occur in child care

by Gail Gonzalez, RN

My first reaction to this fact was shock: It can't be true! But I read further and the *PEDIATRICS* article (Vol. 106 No. 2 August 2000, pp. 295-300) outlined recent research. Three researchers studied 1,916 records of SIDS deaths in 11 states from January 1995 through June 1997. They found that 20.4 percent (or 391 children) died in a child care setting. Even more alarming, the children were often not in the usual high-risk groups.

How could this happen? Certainly parents now know the risk factors and discuss them with caregivers. But maybe not. When visiting programs, I'd see children asleep on their tummies. Caregivers and parents both knew that it was risky, but they said it was the *only* way the child could sleep. After a few days and nights of crying and not sleeping, the parents or the caregivers (or both) decided to allow the child to sleep face down. We know of 391 children who didn't live through the risk.

Here are some things to do—or not do—to reduce the risk of SIDS:

- Do not allow smoking in your family child care home, either during or after care. Second-hand smoke is a SIDS risk factor.

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Child Care Health Connections

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Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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Information provided in **Child Care Health Connections** is intended to supplement, not replace, medical advice.

Visit us on the Web:
www.childcarehealth.org

Ask the nurse . . .

by Terry Holybee, RN

Q *I am an after-school child care provider and many of my kids will be getting scooters over the holidays. I am already dreading the holiday break. How can I make sure they are safe?*

A The scooters we rode around on years ago seemed sturdier than the ones children are using today. But with good education and strict limits, you can reduce the amount of injuries sustained in the scooter revival.

Scooter injuries are on the rise. More than 9,400 scooter-related injuries have been reported in the U.S. from January to August 2000, according to the Consumer Product Safety Commission. Nearly 90 percent of all scooter-related injuries are to children under 15, and children under age 8 account for nearly a third of all these injuries. Most injuries resulted when a rider fell from the scooter, and nearly 30 percent of the injuries resulted in a fracture or dislocation, often to the rider's hand or arm.

The National Safe Kids Campaign offers these tips for keeping your little scooter rider safe:

- Children should always wear appropriate safety gear including a helmet, wrist guards and elbow and knee pads.
- Be sure protective gear fits properly and does not interfere with the rider's movement, vision or hearing.
- Children ages 8 and under should not use scooters without close adult supervision.
- Before using a scooter, the rider, parent or child care provider should check it thoroughly for hazards such as loose, broken or cracked parts, sharp edges on metal boards, slippery top surface, and wheels with nicks and cracks. Defects should be corrected by a qualified repairperson.
- Ride scooters on smooth, paved surfaces free from traffic. Avoid riding on streets or surfaces with water, sand, gravel or dirt.
- Do not ride the scooter at night.
- Do not ride a scooter while holding on to a car, bus, truck, bicycle, etc.
- Limit usage of the scooter to one person at a time.
- Use caution when riding the scooter downhill. If you come up to a steep hill, step off the scooter and walk to the bottom.

As the child care provider, you may decide that letting the children ride scooters while in your care is not worth the additional supervision and worry. Consult with parents before letting children ride scooters at your home or center. Ask parents if any rules have been established, and then let everyone know what your center/home rules are. This will help reduce conflicts later. ❖

Source: *National Safe Kids Campaign*

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Infant/toddler care

When toddlers are difficult

by Cheryl Oku, Infant Toddler Specialist

Funded by the Quality Improvement Program, California Department of Education (CDE), Child Development Division (CDD)

When toddlers whine, cry, bite, push, grab, refuse to cooperate, or just act difficult, caregivers and parents are challenged and exasperated. Our first impulse is to just do something to stop the behavior. But if our goal is to help young children grow rather than just stop the behavior, we need to figure out the causes of their behavior in order to respond and guide them effectively. When a toddler is difficult, take time to observe and ask yourself what he is telling you with his actions, then decide how to respond appropriately.

Developmental reasons

Normal, healthy growth and development are the root of many challenging behaviors such as screaming, biting or saying "No." Toddlers need to develop a sense of self by being assertive. You can respond by redirecting the behavior and finding another outlet for the child. For example, "Since you want to hit, let's go find something safe to hit." Or you can tolerate the behavior and wait for the developmental stage to run its course—while ensuring the safety of others by setting firm limits when needed.

Unmet emotional needs

Nonverbal children communicate their needs and show stress through behavior. Temporary stresses such as moving, holidays, or an absent parent may be the cause. More serious situations, such as ongoing stress, neglect or abuse can cause difficult behavior. Give the child some special time and attention and talk to the parent about what is happening at home.

Lousy local conditions

Lousy local conditions could be anything from a rainy day to too many toddlers in a room. Consider how the environment may be stressful or how a child playing and exploring normally breaks the rules in your setting, such as climbing on furniture or pushing others. Respond creatively by making changes to the room or yard, schedule or groupings. Create times and places for active and quiet play, for social and private play and for special activities.

When a child has not been taught yet

Another possibility is that the child has not yet learned the acceptable way to behave. A 2-year-old who has never been in group care may not know how to wait, take turns or play with other children. You can teach with gentle and nurturing guidance, suggestions, reassurance and by giving opportunities for learning and practicing new skills.

Remember to pay attention to your own reactions. Sometimes a particular child or behavior may upset you or cause you to overreact. In those situations, you may want to seek help from someone else such as another caregiver, who may be able to suggest a different approach. ❖

Health consultant's corner

by Debra Alberstadt, RN, MN, Child Care Health Consultant, Kern County

Guess what's new in Kern County? We've got a Child Care Health Consultant and soon there will be more, thanks to the vision and persistence of my administrator. I took this position a little over two years ago when a grant was offered to Kern County for a Child Care Health Consultant to educate child care providers on Lead Poisoning and Anemia Prevention. Providers were eager to receive information, and this was accomplished by oral presentations, Web pages, articles in local newsletters, and mailings and referrals from various departments in the Community Connections for Child Care agency. Other community agencies also seemed to embrace the position as invitations came from the Lice Committee, Immunization Coalition, Lead Poisoning Coalition, and Kern County Equal Opportunity Health Advisory Committee.

As the project was winding down, it was obvious that child care providers needed and wanted more information on maintaining children's health. Callers wanted advice and resources on diseases such as lice, coxsackie, pink eye, ringworm, diabetes, chickenpox and fifth disease, or information about policies and procedures, antibiotics and immunizations.

Much of my energy in the past few months has been directed towards the development of a policies and procedures manual. Workshops have been provided; these were well attended because of the desire to maintain some form of consistency among staff practices and to uphold health and safety standards for children in out-of-

(continued on page 10)

Is that nit dead or alive—or does it matter?

by Lyn Dailey, PHN

You are probably already unconsciously scratching your head as you read this. You may also find yourself scratching your head as you read about conflicting advice for adopting "No Nit" policies for head lice in your program. There are at least two sides to this issue, and you will need to make a decision that leads you to a policy you have confidence in and are comfortable enforcing.

You may have received a copy of the "Guidelines for School Districts and Child Care Facilities on Head Lice" from the Disease Investigation and Surveillance Branch of the California Department of Health Services. These guidelines recommend that child care programs exclude children with any visible nits until the nits have been removed. While the guidelines also state that children must be treated before returning, providers will have no way of assuring that this has happened. You can print this document from the internet: www.dhs.cahwnet.gov/ps/dcdc/html/publicat.htm or request a copy from the Healthline (800/333-3212).

Be aware that there is also a movement to do away with "No Nit" policies. A recent article in the Pediatric Infectious Disease Journal (Vol. 19, No. 8) concludes that children should not be excluded from school because of head lice infestation. The researchers determined that many parents, teachers, and even medical personnel, are not very accurate at identifying live eggs. They conclude that a "No Nit" policy mistakenly excludes children with dead or hatched eggs in their hair, or with things that just look like nits but aren't. The final conclusion is that a diagnosis of "live head lice infestation" can be made only after microscopic examination.

Be prepared for parents to present you with arguments against a "No Nit" policy, and understand why you do or do not enforce such a policy.

Some points against a "No Nit" policy

- Children without a live infestation may be unnecessarily excluded.
- Families who are unable to comply will be penalized and may feel discriminated against.
- Exclusion may create stigma and/or hysteria and encourage parents to hide information about a child's head lice.

CCHP continues to promote a "No Nits" policy.

Some points in favor of a "No Nit" policy

- Caregivers do not need to distinguish between a live nit and a dead nit, and therefore don't need to require chemical treatment. The focus is on manual removal of nits.
- A "No Nits" policy prevents reinfestations from surviving nits that hatch because *all* nits are removed.
- Reliance on manual removal reduces reliance on chemicals and reduces the likelihood of over-treatment with pesticides.
- Such a policy places responsibility on parents, not providers, for head lice control.

The California Child Care Health Program continues to promote a "No Nits" policy. Feel free to call the nurses on our Healthline to discuss these issues or request a copy of our Health and Safety Note on head lice in child care. ❖

It's OK to share

Share a toy, share a slide,

Share the feelings deep inside,

But never share a hat or comb,

Or lice could make your head a home.

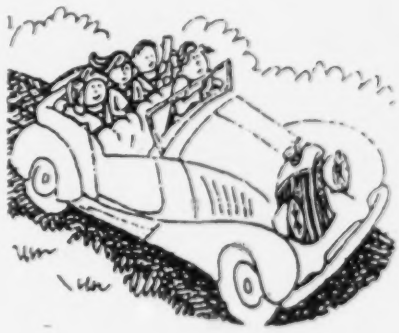
— from the National Pediculosis Association Web site (www.headlice.org)

Parent's page

Safe and healthy holiday travel

by Sara B. Woo, MPH, Project Coordinator, Safely on the Move

The celebrations of the holiday season (beginning with Thanksgiving and continuing through New Year's Day) typically include more time on the road—shopping, traveling and attending holiday parties. Traffic crashes are the leading cause of injury and death to children and adults. A large number of these crashes occur when alcohol consumption is combined with driving.



It is astonishing to think that every 33 minutes someone is killed in an alcohol-related crash. At holiday times, the number of crashes due to drunk drivers can increase by 10 percent or more. In 1998, 38 percent of all the fatal traffic crashes involved alcohol, but during Christmas time nearly 48 percent involved alcohol, and on New Year's Day approximately 69 percent of all fatal crashes involved alcohol.

Every 33 minutes someone is killed in an alcohol-related crash.

Children are too frequently the victims in alcohol-related car crashes. Tragically, from 1985-1996, 3,556 of the 5,555 children killed in alcohol-related crashes were passengers in a car with a drunk driver at the wheel. Nearly 2,400 (67 percent of 3,556) of these drinking drivers were old enough to be the child's parent or caretaker.

Over the past twenty years a lot of attention has been given to the underage drunk driver. Although young people still drink and drive, the number of underage drunk driving fatalities has declined by 33 percent from 1988 to 1998. However, drivers between 21 and 34 years of age have been more resistant to curbing their drinking and driving habits, and are responsible for more than half of all alcohol-involved, fatal vehicle crashes.

Drinking alcohol before driving is often coupled with other risk-taking behaviors. Drunk drivers are less likely to use a seat belt themselves or buckle up their child passengers. Not surprisingly, the likelihood of driving with appropriate safety restraints decreases with the increase in alcohol consumed. ❖

Note: *A new state law which goes into effect Jan. 1, 2002 will require children up to 6 years or 60 pounds to ride in a car safety seat. The current law requires children to ride in a safety seat until they reach 4 years and 40 pounds.*

Safe driving tips

- ***Adopt a zero-alcohol-tolerance*** policy when transporting children.
- ***Always buckle up*** and teach your children to buckle up.
- ***Secure your child*** in the appropriate car seat or safety belt every time they ride.
- ***Check the car seat manufacturer's directions*** to be sure about the correct age and weight limits of the car seat.
- ***Be sure infants ride facing the back*** of the car until they are at least 1 year old and weigh at least 20 pounds.
- ***Use a booster seat*** for children who have outgrown their safety seat. Most children between 4 and 8 years old (between 40 and 80 pounds) need to use a booster seat to help the safety belt fit better.

Sources:

National Highway Traffic Safety Administration. *Traffic Safety Facts 1998. Alcohol*. Washington, DC: NHTSA.

"Characteristics of child passenger deaths and injuries involving drinking drivers," by KP Quinlan, RD Brewer, DA Sleet, AM Dellinger. *Journal of the American Medical Association* 283(17):2249-2252, May 2000.

DIABETES IN THE CHILD CARE SETTING

➢ **What Is It?** Diabetes is a serious illness in which the body is unable to properly change sugar from food into energy. A simple sugar called glucose is the main source of energy for our body. Insulin, a hormone produced by the pancreas—a large gland behind the stomach—helps the body to use the glucose for energy.

Diabetes happens when the body does not produce enough insulin (Type 1 or insulin-dependent), or use it properly (Type 2 or non-insulin-dependent). As a result glucose begins to builds up in the blood, creating high sugar levels in the body.

Children with diabetes usually have Type 1 diabetes, in which the body does not make insulin. They therefore need daily injections of insulin.

➢ **Who Gets It and How?** Approximately 127,000 American children, including 15,000 in California, have Type I diabetes. At some time, child care providers are likely to have a child with diabetes in their care.

Diabetes is not contagious. People cannot catch it from each other. At present, scientists do not know exactly what causes diabetes, but they believe that both genetic factors and viruses are involved. Diabetes can run in families.

➢ **What Are the Symptoms?** Two kinds of problems occur when the body does not make insulin.

1. ***Hyperglycemia, or high blood sugar.*** Occurs with both types of diabetes when the body does not have enough insulin. Symptoms include frequent urination, excessive thirst, extreme hunger, unusual weight loss, irritability and poor sleep, nausea and vomiting, and weakness and blurred vision.

2. ***Hypoglycemia, or low blood sugar.*** Is more common in people with Type 1 diabetes. It is also sometimes called "insulin reaction" or "insulin shock." Symptoms may include hunger, pale skin, weakness, dizziness, headache, shakiness, changes in mood or behavior (irritability, crying, poor coordination), sweating, and rapid pulse. Treatment commonly involves quickly restoring glucose levels to normal with a sugary food or drink such as cola, orange juice, candy, or glucose tablets.

   If not treated properly, it can result in loss of consciousness and life-threatening coma.

➢ **What Factors Affect Blood Glucose Level?** The amount of blood sugar changes and can be affected by many factors such as diet, exercise, emotional stress, illness and medicine.

Exercise helps to lower blood sugar. Regular exercise is important because of the need to balance the effect of exercise with food and insulin. If possible, the child should test blood glucose levels before taking part in a game or sport to determine when to eat a snack and how much food to eat.

Types, amount, and frequency of meals and snacks have different effects on blood sugar. Children with diabetes need special diets in reasonable amounts, and on regular schedules. Crackers with peanut butter or cheese, pretzels, apples and juice make ideal snacks.

A child with diabetes may need to eat a snack before, during, or after energetic exercise.

Stress from a cold, sore throat, or other illness may increase the level of blood glucose.

➢ **The Law and Diabetes:** The Americans with Disabilities Act, a federal law, considers diabetes a disability, forbids discrimination against the disabled, and puts legal responsibility on child care providers to care for the special needs of children with diabetes.

Effective January 1, 1998, child care providers in California are allowed to perform a blood-glucose test (using a finger-stick test) on a child in their care.

However, they are not required to give an insulin injection to any child in a child care facility.

➢ **Blood Glucose Testing:** Regular testing of blood glucose levels is a very important part of diabetes care. Testing is done by taking a drop of blood, usually from a finger, and placing it on a special test strip in a glucose meter. Glucose meters are easy to use, and most children quickly learn how to do their own blood glucose tests. A normal blood glucose level is between 70 and 120 mg/dl. Keeping blood glucose levels within this range is rarely possible in children with diabetes. A health care provider will often identify a target range for blood glucose levels - for example, 80 to 180 mg/dl.

➢ **How Is It Managed?** Care for diabetes is more flexible than it used to be. It requires self care or assistance with care if the child is very young. Children with diabetes can participate in all child care activities. Except for paying attention to their special care plan, you do not need to treat them differently just because they have diabetes.

The goals for treatment of diabetes in children are to:

(a) Maintain normal growth and development

(b) Keep blood glucose levels within a target range (not too high, not too low)

(c) Promote healthy emotional well being.

Child care providers in coordination with parents and health care providers can prepare a special care plan to meet the special needs of children with diabetes, and help them lead healthy, active, and fulfilled lives without having to change their regular program. A written, special care plan should include:

- When to test blood glucose and take insulin
- Regular meal and snack times
- Preferred snacks and party foods
- Usual symptoms of hypoglycemia and preferred treatments
- When and how to notify the child's parents of problems
- When and how to contact the child's health care provider
- Who will give insulin injections when needed

Preschool-age children with diabetes often need frequent blood glucose tests because they have not yet learned to recognize the symptoms of low blood sugar, can't tell what they feel, or may try to avoid or delay finger-prick and insulin injections. They may also drink and urinate a lot, so make sure they can go to the bathroom as often as they need.

Providers considering or already performing the finger-stick test must follow "universal precautions" at all times. For more information on diabetes, please call our toll-free Healthline at (800) 333-3212 or American Diabetes Association (800) DIABETES.

Summary of Key Points

Good diabetes care practices include:

- eating reasonably, consistently, and on schedule
- testing blood glucose levels regularly
- adjusting insulin as glucose levels and activities warrant
- exercising regularly

References:

American Diabetes Association. Assembly Bill (AB) 221 Chapter 550, Statutes of 1997, Section 1596.797 of the Health and Safety Code.

By Rahman Zamani, MPH (2/27/98)

Diversity

Facing the diverse needs of all children

by Rahman Zaman, Program Analyst

Being aware of the trends and projections of population changes in our state, most of us were not surprised by the Census Bureau's announcement at the end of August that whites are not a majority in California any more. According to the census estimates, one of every two Californians, or more than 50 percent of the population has a non-white racial/ethnic minority background.

The increase in racial/ethnic and cultural diversity is reflected in many early childhood settings. While all children can benefit from exposure to multilingual and multicultural learning environments, they can also pose a serious challenge for providers. To help children enter schools healthy and ready to learn, child care providers need to learn more about people with different cultural backgrounds, values, beliefs and about their responses to everyday situations.

Children have unique health needs which can be due to cultural, linguistic or socioeconomic differences. For example, African Americans and Latinos have higher rates of SIDS, infant mortality, diabetes, low birth weight and HIV infections, as well as higher rates of disabilities. Lower-income families of all ethnicities often have a lower level of parent education; they can lack access to quality physical, mental and dental health care services; they can be exposed to environmental hazards such as lead, asbestos, pesticides, industrial waste both at home and in their neighborhood at a high rate than others.

Child care providers can play a very important role in supporting the healthy development of all children in their care. They can examine the children's health history and needs, and play a role in their healthy social, emotional, intellectual and physical development. Quality child care promotes healthy behavior, reduces the risk of disease, and provides necessary support and links to resources.

Children have unique health needs which can be due to cultural, linguistic or socioeconomic differences.

Child care providers are not alone in their efforts to provide quality child care. As you are aware, the California Child Care Health Program (CCHP), through its new Child Care Health Linkages Project, will develop an infrastructure for linking child care providers and families in child care programs to health and safety resources and services in up to 20 counties. By increasing their linkages with the health care community and gaining better knowledge of effective practices, we hope that providers will be able to create environments responsive to the diverse needs of all children. ❖

Tips for reducing the risk of SIDS

- Always place babies on their backs to sleep.
- Place the baby on a firm mattress and remove all pillows, quilts, comforters, bumper pads, stuffed toys and other soft items from the crib.
- Do not place the baby to sleep on a waterbed, sofa or chair, soft mattress, sleeping bag, pillow, or any other soft surface.
- Do not allow babies to share a crib, even if they are siblings or twins.
- Ask the parents to provide a sleeper garment. Dress the baby in it for sleep instead of covering him/her with a blanket or comforter.
- Make sure that the baby's head stays uncovered while he/she sleeps.
- Do not let babies sleep in a room where smoking is allowed (even if no one smokes while the babies are in the room).
- Make the families you serve aware of the steps you take to reduce the risk of SIDS while caring for their children.
- Establish a written policy stating that children will be placed to sleep on their backs unless the child's health care provider provides written instructions for another position.

*For more information or a new fact sheet, **SIDS and the Child Care Provider**, please call the SIDS Alliance toll free at (800) 221-7437.*

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Avoiding provider burnout

by Judith Kunitz, MA, Child Development Specialist

The term "burnout" is often tossed around lightly after a hard day of working with young children in a child care setting, but provider burnout can be a serious problem for the early childhood profession. It is often responsible for the high rate of teacher turnover which, in turn, affects the quality of care young children receive. The profession of early childhood education involves long hours, low pay, minimal benefits, low status and the huge responsibility of caring for young children. To avoid losing qualified child care providers, it is important to look at the signs of burnout and find ways to reduce stress and burnout in the daily lives of child care providers by addressing the problems that cause it.

There are three main indicators that a provider is suffering from job burnout:

1. The provider experiences some degree of physical and emotional exhaustion including fatigue, tension headaches, stomach problems, insomnia and muscle tension.
2. The provider becomes disillusioned with the job (and life in general), displayed by distancing and isolating oneself from co-workers, irritability, anxiety and a growing cynicism.
3. Self-doubt and blame surface, and can include depression, feelings of low self-esteem and incompetence, guilt and an overriding sense of sadness.

One way to address provider burnout is to add stress management techniques to staff education meetings and trainings as a benefit for all caregivers. Work with your supervisor to ensure that personnel needs are addressed, such as a quiet place for breaks each day, positive feedback and small rewards for excellence. Stress-reduction support groups can be organized to help talk about teaching frustrations and to gain peer support and insight from one another. The sources of professional burnout and how to cope with them should also be covered in training for new early childhood educators. Learning coping and self-assessment skills can be useful in avoiding burnout and compassion fatigue throughout one's teaching career.

Early childhood development specialist, Nancy Baptiste, writes that self-assessment "in the personal domain helps us to understand and know who we are. Self-assessment in the professional domain helps us to understand and know our knowledge, skills and attitudes in our work life." As she reminds us, early childhood educators must make sure that they have not "gone beyond burnout and turned a love for and commitment to working with children and families from a passion into an addiction." It is important that all providers examine how they can make personal and professional changes to avoid burnout in order to make their lives fuller and healthier. ✣

Sources:

"Always Growing and Learning: A Case for Self-Assessment," *Day Care and Early Education*, by Nancy Baptiste, 1994.

Avoiding Burnout: Strategies for Managing Time, Space and People in Early Childhood Education, by Paula Jorde-Bloom. New Horizons, Lake Forest, IL, 1982.

Inclusion insights

Inclusive child care: meeting diverse abilities

by Pamm Shaw, MA and Sandra Zehaye, MA, Disability Specialists

You may have asked yourself, "Do I have an inclusive program? Am I truly providing appropriate experiences for children with diverse abilities? Am I able to respond to the individual strengths and needs of all children in my care? Am I working together with the families to meet their children's needs?

The answer may be yes to all of the above. When assessing your current environment, consider the following:

Providing early care and learning activities for young children with diverse abilities takes place in quality child care programs daily. Children learn differently, speak different languages and vary substantially in social and cognitive skills. In any given setting, a child may have an arm in a sling, another child may experience separation anxiety, and yet another may appear withdrawn from the other children in the group. Providers use their observation skills and knowledge of child development to provide the necessary learning experiences within the program and intervene when they recognize it is necessary.

In an inclusive child care program, children with and without disabilities are included in all daily activities in much the same way you would include children with diverse social, language and cognitive abilities. Some children have needs that are unfamiliar, however, and adjustments are made to include all children in the same routines and play activities. Most toys, play materials and equipment are appropriate for

(continued on page 10)

Legislative update

by Marsha Sherman, Executive Director, CCHP

Child care health has not made great legislative gains this year. However, more and more policymakers know of the Child Care Health Linkages concept, and we did receive a large grant from the California Children & Families Commission to fund up to twenty counties for Child Care Health Consultant Projects. We were hoping that legislation would fund additional counties, but the CCHP-sponsored bill, **AB561** (Romero), did not get approved by the Senate Appropriations Committee. However, another senator has agreed to sponsor the same concept in a bill for the next legislative year. We will keep you posted.

AB443 (Mazzone) has met a similar fate. The "Parent Services Project: Family Support in Child Care and Development" failed in the Senate Appropriations Committee. We hope they don't give up, either.

Here are updates on some other important bills we have been following:

AB212 (Aroner) provides matching funds for local county projects that have established CARES Projects (stipends for providers who stay in the field and continue their training). It has been signed by the governor and will become law in January 2001.

AB1594 (Florez) would require that children be vaccinated against Hepatitis A before entering child care and school. Vetoed by the governor.

SB1619 (Alpert) requires the Department of Social Services to establish a work group to review playground safety regulation for child care programs, and includes the submittal of recommendations to the Legislature by November 1, 2001. Signed by Governor Davis in September 2000.

For detailed information on these bills, read the text online at www.sen.ca.gov/. To stay current on bills that impact child care and development, subscribe to On the Capitol Doorstep by calling (916) 442-5431, and stay tuned for the year 2001 legislation. ❖

Linkages RFA packet now available

The Child Care Health Linkages *Request for Applications (RFA)* packet is available from J. Kunitz at CCHP by mail at 1322 Webster St., #402, Oakland, CA 94612-3218, by e-mail at jkunitz@childcarehealth.org, or by calling (510) 839-1195.

Consultant *(continued from page 3)*

home care. Providers realize the responsibility imposed on them in caring for five to 10 children for eight to 12 hours every day. Some providers are working with few or no policies, or with policies which have been buried in the archives for years! Providing workshops on policies not only allows center staff to make time to review policies, but to communicate with other staff who have encountered problems, and to create new policies where they are needed.

Child care health consultancy is alive and well in Kern County, gaining ground for quality child care by assisting in early intervention, accessing health care and preventive services, maximizing, integrating and coordinating all services to better meet the needs of Kern County's children. ❖

Inclusion *(continued from page 9)*

children with disabilities and, if needed, can be adapted or modified.

Early childhood programs provide opportunities in natural environments for all children to grow and develop. When children with disabilities participate in valuable learning experiences with other children they develop a sense that everyone, regardless of ability or disability, can contribute. Establishing partnerships with families is crucial to maintaining the success of inclusive child care programs as it allows parents the opportunity to provide input about their children's strengths, needs and interests. By responding to individual strengths and needs, providers can continually make changes in activities and routines to benefit all of the children within the environment. ❖

SIDS *(continued from page 1)*

- Remove comforters and fluffy pillows that are another risk factor. Infants need a firm surface with no loose bedding. Bean bag chairs and waterbeds are dangerous for babies. Make sure the baby's head remains uncovered during sleep.
- Do not overdress baby or overheat baby's room.
- Breast milk has been shown to reduce the risk of SIDS. Encourage the moms in your program to continue breastfeeding.
- Ensure that infants' immunizations are kept current. Keeping babies healthy also reduces the risk of SIDS.
- Early and regular prenatal care can also help reduce the risk of SIDS.

As a provider, you are a trusted and valuable resource to parents. Share this information with the families of children in your care.Call theHealthline (800/333-3212) or the California SIDS Foundation (800/369-SIDS) for materials to share with parents and peers. ❖

Be smart *(continued from page 1)*

How can you avoid this sticky problem? First, everyone needs to learn more about it. The USDA has a free packet and teaching materials (call 888/SAFEFOOD or visit www.cfsan.fda.gov.) The Child Care Food Program, if you are a member, has materials and consultants who can help (call CCFP's Ed Mattson, Roundtable, at 925/686-0522).

Meanwhile, here are some good tips to follow:

- ***When shopping***, separate meats, fish and poultry from other items with plastic bags.
- ***In the refrigerator***, use meat drawers, plastic bags or plastic containers to separate foods.
- ***Store eggs in their original container*** to avoid cross-contamination if they should break.
- ***Wash surfaces*** with a clean cloth and hot soapy water before and after they touch food.
- ***Sanitize surfaces*** with a solution of one teaspoon bleach in one quart of water made freshly every day.
- ***After marinating*** raw meat, seafood or poultry, throw the sauce away. It has raw meat juice in it (when barbecuing, too).

Learning food safety is a good lesson for the child care setting. Many children have access to the cupboard and refrigerator at home; these good practices can be shared with their families. Send for your own training packet soon by contacting the FDA District Office, Public Affairs at (510) 337-6888. ❖

For more information, visit www.homefoodsafety.org. For a free Home Food Safety brochure, call (800) 366-1655.

Health and Safety Calendar

November

8-11: National Association for the Education of Young Children Conference. Atlanta. NAEYC, 1509 16th St, NW, Washington, DC 20036; (800) 424-2460; www.naeyc.org

16: The Great American Smokeout. "Want three good reasons to quit smoking?" (Your family, your children and you.) To order a free copy, call the American Cancer Society at (800) ACS-2345 or your local ACS office or visit www.cancer.org. If you're a parent or child care provider who smokes, this pamphlet from the American Cancer Society provides compelling information on the dangers of smoking and second-hand smoke to help you give it up for good.

20-26: As part of the Buckle Up America campaign and America Buckles Up Children, thousands of law enforcement agencies nationwide are stepping up their enforcement activities to protect children from two of the greatest risks they face: riding unbuckled and impaired drivers.

December

Safe Toys and Gifts Month/Prevent Blindness America (800) 331-2020; www.preventblindness.org/children/safetoys.html

Resources

Products, books, furniture and posters described in this Resources section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Becoming the Parent You Want To Be, by Laura Davis and Janis Keyser. Broadway Books, New York, 1997 (www.becomingtheparent.com)

The Child Under Six, by James Hymes. Consortium Publishing, West Greenwich, Rhode Island. 1994

Join the Debate: Voter Guide on Health Issues is a free briefing book on health care policy options at stake in the November election. Contact Kaiser Family Foundation at (800) 656-4533 or visit www.kff.org.

101 Tools for Tolerance lists activities aimed at fostering tolerance at home, school, work and in the community. Free. National Campaign for Tolerance, Southern Poverty Law Center, 400 Washington Ave., Montgomery, AL 36104, online at www.tolerance.org

Online Resources

Head lice poster: "Because it's not about lice, it's about kids." National Pediculosis Association. www.headlice.org

To keep kids safe on scooters and other safety topics, contact the National Safe Kids Campaign, (202) 662-0600, or online at www.safekids.org.

"For Kids' Sake Think Toy Safety" Consumer Product Safety Commission's Publication #281. A guide to choosing toys for children and infants. Includes information on toy labeling and the Child Safety Protection Act. Available in English or Spanish, can be downloaded or ordered at http://www.cpsc.gov/cpscpub/pubs/toy_sfy.html

Learn the effects of drinking and driving: Get a copy of the November Operation ABC Mobilization Focus materials from the National Highway Traffic Safety Administration by logging onto their Web site at www.nhtsa.dot.gov/people/outreach/safesobr/abcmobilization/index.html.

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